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Official Report of Debates (Hansard)

E-26

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E-26

**Standing Committee on
Estimates**

Ministry of Health
and Long-Term Care

**Comité permanent des
budgets des dépenses**

Ministère de la Santé et des
Soins de longue durée

2nd Session
41st Parliament
Tuesday 31 October 2017

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41^e législature
Mardi 31 octobre 2017

Chair: Cheri DiNovo
Clerk: Eric Rennie

Présidente : Cheri DiNovo
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
ESTIMATES

Tuesday 31 October 2017

COMITÉ PERMANENT DES
BUDGETS DES DÉPENSES

Mardi 31 octobre 2017

*The committee met at 0900 in room 151.*MINISTRY OF HEALTH
AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good morning, everyone. We are going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of 11 hours and 21 minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meeting that the minister has responses to, perhaps the information can be distributed by the Clerk. Are there any items, Minister?

Hon. Eric Hoskins: No.

The Chair (Ms. Cheri DiNovo): Okay. When the committee last adjourned, the third party had three minutes and 40 seconds remaining in their rotation. Madame Gélinas.

M^{me} France Gélinas: Well, I will use my three minutes and 40 seconds wisely and talk about a hospital near and dear to my heart, Health Sciences North, which looks after me and my family and everybody else.

I had the pleasure of attending their annual general meeting in June, like I do every year, and they shared with us this little graph. I will give it to the Clerk. It's basically a graph that showed medical bed occupancy rates. You can see from the graph that they distributed at their annual general meeting that they have been at over 100% capacity for quite some time. They explained that this has brought upon a \$7-million pressure due to overcapacity and that the hospital was reporting a \$7.1-million deficit.

On average, Health Sciences North is functioning with 30 to 35 people in hallways. We don't have TV rooms; we don't have lounges anymore. We used to have a very nice garden area. None of this exists at the hospital anymore. Everything has been converted into a place to house patients—not to mention the corridors and hallway ways.

You have announced eight additional transitional beds for Health Sciences North. Can we expect anything else to help with the overcapacity?

Hon. Eric Hoskins: Good morning, everyone, and happy Halloween.

M^{me} France Gélinas: Happy Halloween.

Hon. Eric Hoskins: Are you referring to transitional as opposed to in-patient acute?

M^{me} France Gélinas: I'm referring to Health Sciences North having 30 to 35 people over capacity every single day and wondering what you can do to help them.

Hon. Eric Hoskins: Okay, fine. I'm just confused because you referenced eight beds, and I know that we've allocated 16 acute in-patient beds to Health Sciences North.

Also, if you haven't heard, I should reference that this morning, I believe Health Sciences North was recognized by the American College of Surgeons as being one of the top 10 hospitals in a surgical capacity in North America, which is quite an accomplishment for Health Sciences North. They're doing exceptional work there and that, I think, is a reflection of the high quality of care that they're able to provide with the resources they have, in partnership with the government.

We have allocated 16 beds to Health Sciences North. There are an additional 31 beds set aside which have, as of today, not yet been allocated. The North East LHIN, of course, will work with its partners in the hospital system, including Health Sciences North, to look for additional opportunities. Those additional opportunities may, if not likely will be, in part at Health Sciences North itself.

We've been working closely with Health Sciences North over the course of the past year. We recognize the challenges that they've been facing. We have, of course, increased their budget in addition to the bed allocation. Their budget—Health Sciences North actually was increased by just under \$6 million this fiscal year.

The Chair (Ms. Cheri DiNovo): I'm afraid that time is up, Minister. Thank you.

We now move to the government side. Mr. Rinaldi.

Mr. Lou Rinaldi: Minister, I just want to take a minute, if I can, to express my gratitude to the folks at Northumberland Hills Hospital—this past weekend, a horrific tragedy happened in the small community of west Northumberland, Cobourg, specifically—and recognize the challenges the staff, police, ambulance and, frankly, everybody that was in the hospital faced; it was fairly traumatic. It ended up not in a nice way but, in the end, it could have been a lot worse. So I just want to express my gratitude to the folks on the ground. My understanding is that the hospital is back to full operation; nevertheless, there's a cloud hanging over them and I just hope this

doesn't happen again in any place in this province or this country.

The Chair (Ms. Cheri DiNovo): Madame Des Rosiers?

M^{me} Nathalie Des Rosiers: I would like it, Minister, if we could now talk about the opioid crisis. I think it has been challenging for people across Ontario to come to grips with this crisis. I know that in the riding that I represent, Ottawa–Vanier, this has raised a lot of issues, both in the shelters and just around the entire city. We have had many people who have tragically lost their lives in the context of this crisis.

I know that last year, quite a comprehensive plan had been developed by the government and, again, I recall that recently additional investments were announced as well to respond to the crisis. It's very challenging and it would be really helpful for us to understand a little bit more in depth how indeed we can respond to this crisis, what government has in stock to adequately respond to this. Give us a little bit of an overview and a little bit—I think it's serious enough that we would like to have a bit of an in-depth analysis of how we approach a crisis like this.

Hon. Eric Hoskins: Well, thank you, I appreciate the question. This is an extremely important question, as well. I just want to, before I begin, add to the member from Northumberland–Quinte West's—correct?—comment with regard to the Northumberland hospital. I had the opportunity to speak with Linda, the CEO of the hospital, Linda Smith—sorry, Linda Dale.

Mr. Lou Rinaldi: Davis.

Hon. Eric Hoskins: Linda Davis. Wow. Okay. Linda Davis.

It's been a very trying time for that entire community, including the front-line staff and the administration, the police, the first responders. But I was very proud of the response that was taken and the response that continues to be taken by the leadership of the hospital. Linda outlined the processes and the supports that they have put in place to deal with an incredible tragedy which has far-reaching implications for that hospital and for the community. In terms of the impact, the mental impact on the front-line staff will be a challenge which is going to be ongoing for some time, to make sure that the necessary supports are in place. So, thank you for referencing that.

With regard to opioids, there is no question—in this province and in many parts of the country—it is a public health emergency and a public health crisis, and I have referred to it as such in the context of Ontario many times. Our response has been nothing short of a response which is appropriate to a crisis or an emergency that could take place in any context within the health care system or the health of the population. I have often said that when it comes to mental health and addictions, we need to not only increase our investments, which we are doing, but particularly with individuals with substance use disorder, those with opioid use disorder—they not only deserve our respect and our care and our support

and as equal access to the health care system as anyone else in Ontario, but they need to be treated with respect and with dignity as well. It's critically important.

As we know, there is tremendous stigma still lingering against those with mental illness. It is magnified many times for those who have substance use disorder, particularly opioid use disorder. They are very vulnerable individuals, they are often marginalized, they have a history of mental and often physical trauma—the preponderance or at least the vast majority do—and all of those pieces that I just referenced need to form the foundation of our approach.

0910

I think I've made three or perhaps four funding announcements with regard to our response that go back more than a year, a year and a half or so, where our allocation or dedicated funding to respond to the opioid crisis is in the order of just under \$300 million over a three-year period. It's a substantial investment, but it reflects the investment that's required to lessen the epidemic or the crisis and hopefully end it.

What's most worrying, I think, is the increase that we're seeing across the country, including in Ontario, in the presence of fentanyl in illicit drugs. Individuals who may have a history of substance abuse or opioid abuse are literally being poisoned. They're accessing, in most cases, their normal supply, but that supply has become tainted or poisoned with fentanyl and so the individual doesn't know the toxicity of what they're consuming. That has led to frequent overdoses.

We saw in Abbotsford in British Columbia, I believe just this past weekend, certainly within the last week, five individuals dying in a single day of opioid overdose. Fortunately, in Ontario, the situation hasn't reached the levels that we see in British Columbia, but our response, I would say, has been as vigorous; in fact, I believe we have the best and most comprehensive, most proactive holistic response to the opioid crisis of any jurisdiction in Canada. I firmly believe that.

We began a long time ago, a year and a half or so, with making naloxone available free of charge through pharmacies, and I think now we're up to about 1,500—perhaps more—pharmacies across the province in 150-plus communities providing the naloxone kits, which are a lifesaver for individuals who overdose. If their friends or a health care provider or a peer support worker happen to be present at the time—or a first responder—and they can administer naloxone, either injectable or through nasal administration, it is literally a lifesaver. It temporarily reverses the effects of opioids. It doesn't permanently do it, but it buys you that time so that you can then get them to an environment like an emergency room where they can be revived and sustained.

With naloxone, we've now increased its availability not simply through pharmacies—and I think I mentioned that not only do we provide the kit but pharmacists provide the training to the individual. We've expanded naloxone so that we're now distributing, I think, about 7,000 kits per month, including through our public health

units, through community agencies and through some of our first responders as well—every means possible to effectively, as much as possible, flood the province with naloxone so that it is readily available.

But we've moved far beyond that very focused response, understanding that the response to the crisis needs to be holistic. It needs to tackle everything from ensuring appropriate prescribing of legal or licit opioids by our health care providers—we've got Health Quality Ontario working along with others to develop standards. We have recently promulgated national guidelines on opioid prescribing as well that came out of McMaster a few months ago, and we're working with our partners in the health system, particularly our primary care providers—doctors and nurse practitioners—to ensure that they have the supports they need to be able to make those decisions that are most appropriate for their patient.

Taking the next step forward, we also announced about a year ago additional funding for pain clinics. We have 17 pain clinics across the province. We're expanding them. We're expanding the existing and adding new ones. I think there was a \$17-million investment in pain clinics, understanding that health care providers, physicians for example, need to have access—their patients need to have access to those alternatives to taking opioids. Or if their patient is taking opioids for, say, a chronic pain ailment where in fact the evidence of the utility of opioids for chronic pain is limited, so that the health care provider has other options that they can provide to the patient—for example, to pain clinics, to other allied health professionals—to provide the best possible and alternative treatment to the prescribing of opioids.

We've also announced recently just short of \$100 million which will go to supports for individuals with opioid use disorder who are at a point in their lives where they want support and they're ready to go in to, say, detox, and the other supports for treatment—either day treatment or residential treatment—that are so important to giving that individual the chance to get back on their feet.

There are a myriad of options available out there. We're investing in them and expanding some of the existing ones. One of the ones that I'm most excited about is the rapid access clinics, which are often located in hospitals. An individual might come into a hospital with an overdose, be revived, and immediately they'll be referred to one of the rapid access clinics that sort of takes the baton from the ER docs and the ER staff and begins the process of providing them with the support and linking them with community and other supports that are required, but also access to detox, access to treatment—all of the resources that they would properly need, including the human resources, the staff, that can provide them with the best chance to rehabilitate themselves.

So you can see it's a continuum. It continues along to—one part, which is of critical importance, is for us to provide maximum support to harm reduction workers and peer support workers, those who are on the front line. Again, we're talking predominantly, on the illicit side, at

least, of highly marginalized, highly vulnerable individuals. We have a great resource across the province, which is our harm reduction workers. Many of them actually have lived experience with opioid use disorder, so they are so well-placed to be able to provide the best possible relationship, but also develop and provide the supports and link that individual to the supports that are available for them.

We're very intent on increasing their capacity to do their job, understanding how important they are to the solution to what is, unfortunately, a chronic problem, a chronic crisis, if you can call it that, a chronic emergency. We announced significant new investments recently, a couple of months ago, for \$21 million, I believe—of that order—to go to support harm reduction workers and front-line workers.

Also, recently at the federal-provincial-territorial meeting two weeks ago, we had a very serious discussion on the opioid crisis nationally. I referenced specifically the need for all of us, including the federal government, to find additional measures and steps that we can take to further support our harm reduction workers, because they're so vital to an effective response to the crisis.

We have as well, I think—if you live in Ottawa or Toronto, you're well aware of the development of supervised consumption sites. We have three in Toronto that have been approved—two at community health centres and one at a public health unit—and we've approved one in Ottawa, currently, at a community health centre.

It's in your riding?

M^{me} Nathalie Des Rosiers: It's in the riding, yes.

Hon. Eric Hoskins: These are entities that already have a relationship with the population we're trying to support and reach, often through needle exchange programs and other programs, so it's a natural extension of that.

If you look at the crisis through a harm reduction lens, a public health lens, it's an appropriate response. If you can provide, as these sites are or will be doing—including the one at Moss Park, which is staffed by volunteers and having an incredible impact in terms of reversing and preventing overdoses; Inner City Health in Ottawa is another example. These are locations, all of them, where the staff are supervising the individuals with opioid use disorder on their consumption of drugs. It may be injectable; it may be through other modalities.

0920

Through that supervision, they're not only able to reverse overdoses with naloxone should they happen, but they're also able to provide other supports and hopefully connect those individuals to supports that will help them, hopefully, in their addiction, or certainly at least cope better with it, but, also, other supports that they might need in terms of shelter and other challenges that they may face, which often have led them to their current situation. We continue to support communities that are asking us to help them make available supervised consumption sites. Again, because of the—literally—poisoning of the illicit market, it's an important measure to take.

I've spoken a lot about the marginalized population and the vulnerable population, but it's also a crisis which, regrettably, can affect just about anyone who uses—well, to a lesser extent—illicit legal drugs, but certainly illicit drugs. The weekend warrior that goes to a party or to a nightclub and takes a substance that they might think is ecstasy, and it turns out it's laced with fentanyl or, even worse, which we're beginning to see, including in this province, carfentanil, which is 100 times more potent.

For that reason, we are providing resources more broadly, including—which I haven't touched on yet, but I'm sure I'll give ample time to Sharon Lee to comment on it. How many minutes do we have left?

The Chair (Ms. Cheri DiNovo): About two and a half.

Hon. Eric Hoskins: Okay, you'll have lots of time. For that reason, I want to touch on not only do we have a separate tranche of funding for—perhaps with the time limitations, I won't be able to get into the details—an integrated but parallel partnership with indigenous communities, which is critically important. Because while they are overrepresented in the groups that we're talking about, regrettably, we also need to have not only a somewhat unique approach, but an approach which is firmly embedded in that culture of respect and understanding the nature of the partnership and the capacity that exists within First Nations and other indigenous communities.

The last thing I'll touch on is the public awareness and education, which sort of gets my reference to the weekend warrior. It's critically important for us to—and we're well on our way and we'll shortly have public education materials. Some are available through public health units, through harm reduction workers, front-line workers, first responders, in our schools as well. You can imagine it's critically important that we provide education and awareness to, say, kids in high school, as well as their parents, about the risks that are inherent should they take illegal drugs, particularly now with regard to the presence of fentanyl.

It's a very broad, comprehensive, multi-faceted approach that's required—and data management as well. We have the province's first ever provincial overdose coordinator, who is our Chief Medical Officer of Health, David Williams, and he's working very closely with the coroner's office and others. All emergencies are now providing on a weekly basis their overdose data; we reflect that back to public health and to the general public. The coroner's office is very engaged in making sure that we've got the most up-to-date, reliable data as well and reflecting that back to public health as well as to hospitals and harm reduction workers and the general public. It's a very strong and multi-faceted approach, and I can't believe or imagine that we're anywhere near the conclusion of this crisis. I'm deeply concerned, and we're seeing that in all likelihood it's going to get worse before it gets better. It's only when we're all working together in that comprehensive way that we're going to be effective. I suspect—

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up, Minister.

Hon. Eric Hoskins: —that my time is up.

The Chair (Ms. Cheri DiNovo): We now move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you, Chair. Good morning, Minister. Thanks again for being here.

I just had a follow-up question. The last time I was here speaking with you it was regarding the public health expert panel. A report—you were last discussing how they were doing a review at the end of October with an AMO table. Can you just let us know what you have done to reach out to the public in order to have consultation on this expert panel?

Hon. Eric Hoskins: Okay. Do you want to speak to that, because I'm just a little—I was between things.

I'm going to ask the deputy to speak to that.

Dr. Bob Bell: Thanks, Mr. Yurek. I think the date you're referring to is the completion of public consultation and public response to the expert panel report. We asked people to provide us with their responses by the end of October. I believe that's what Mr. Yurek is referring to. Why don't you come up?

Mr. Jeff Yurek: Did you reach out to—how did you publicize to people to actually comment?

Dr. Bob Bell: Super. I'll ask ADM Roselle Martino—if that's okay, Minister—to describe that process of consultation.

Ms. Roselle Martino: Sure. Certainly. Hi, Roselle Martino, assistant deputy minister in the population and public health division.

We sent out an email with the link to the report to submit submissions through a number of different stakeholders. We also submitted it through a number of different patient-family organizations. We also asked public health units to get the input from their local communities when they were submitting their input to the ministry. That is how we were getting the public's support into the report as well.

Mr. Jeff Yurek: Would you be able to give us a list of the stakeholders you sent the email to?

Ms. Roselle Martino: We will consider that, yes.

Mr. Jeff Yurek: Okay. Thank you.

Minister, back to you: Dealing with your OHIP+, what are the assumptions behind the \$450 million that have been budgeted for OHIP+?

Hon. Eric Hoskins: I might get the ministry as well to comment on this, if you want to get into more detail. Certainly, the ministry estimate of the annual costs—of course, because it's starting January 1, this fiscal year the costs will be substantially less than that, but it's been estimated at an annual cost of \$450 million. I'm sure that we can provide more details.

Ms. Suzanne McGurn: Good morning. Suzanne McGurn, assistant deputy minister and executive officer for the Ontario Public Drug Programs. Thank you for the question. The first assumption for the cost is that we have acknowledged all of the existing funding in our—the \$465 million is incremental costs above what is already being paid for, whether it's through the Trillium program or inherited metabolic diseases.

The other costs that have been considered—we're looking at the actual number of children, the utilization rate of prescriptions by children at various ages, for example through Stats Canada, and subsequently, we have validated the original assumptions with both additional information from IMS Brogan as well as insurer information as we have been working forward with them.

It has taken into account other assumptions as well, such as where individuals will be benefitting from pCPA prices for some of the products as well as generic pricing.

Mr. Jeff Yurek: You probably should sit there for a little bit. Minister, why wasn't this \$450 million included in this year's budget?

Hon. Eric Hoskins: Go ahead, Suzanne.

Ms. Suzanne McGurn: One quarter or \$115 million incremental cost was included in the 2017-18 budget, and it is for the portion of the \$465 million that will be spent with the launch of OHIP+ on January 1, 2018.

Mr. Jeff Yurek: Okay.

Hon. Eric Hoskins: I'm just going to add that it was not only fully costed, but it's part of the fiscal plan.

Mr. Jeff Yurek: We've seen data that 45% of total claims for the under-25 age group will be covered by ODB, but that means that 55% of the RxS for young people will still have to be paid out of pocket by those without private insurance. What are your plans to assist those who fall outside that range that will be covered?

Dr. Bob Bell: Maybe we could ask Suzanne to reflect on the interaction that has occurred between the public drug branch and the CLHIA, the association of insurers, and the discussion that has occurred around the Exceptional Access Program, the ability of parents to move their children over to the Exceptional Access Program. Suzanne, would you comment further on that?

Ms. Suzanne McGurn: Sure. Obviously, children's medicines are quite different than medicines you would see for older-aged individuals: less chronic medicines, acute etc. Many of the individuals and children who will be transitioning will do so in an acute way, so there will be no need for any different assessment than has historically been done. As clinicians, both nurse practitioners and physicians, become familiar with the ODB formulary, their prescribing of medications that are covered by ODB, similar to what they do for other populations, whether on Trillium or for seniors, will become second-hand.

0930

With regard to medicines that do tend to be on our EAP formula, I think it's important to recognize that in a number of cases, insurers, too, have preapproval processes. But we've been working very closely with CLHIA and with specific groups of clinicians to identify the information needed for timely assessments and transition of individuals from private insurers etc. That has included, for example, working with the Ontario rheumatoid arthritis association on a facilitated-access mechanism; looking at streamlined processes for information about children who need to be assessed, able to be completed by clinicians and assessed prior to January 1; as well as

working with insurers to make sure that after January 1, no children fall through the cracks, so that we have a risk mitigation approach that will allow us to make sure that children who turn up at pharmacies have pharmacists who have correct information, have clinicians who have been pre-educated about the program, and certainly limit any disruption for children or their families after January 1.

Mr. Jeff Yurek: What exactly have you done to ensure—I get what you're saying about the EAP process, which is quite onerous and lengthy and usually has quite a few denials. I do know that private insurance companies have a bigger formulary than the Ontario Drug Benefit, and there are a number of medications that aren't on the drug formulary that people will be switched to come January 1.

You talk about educating clinicians. November is tomorrow; we're two months away from launch date. There are going to be parents coming in to get their child's refill in mid-January. What have you done with private insurance to ensure that, for the 55% of drugs that aren't covered, those patients are still going to have access come mid-January when they come for their refill?

Dr. Bob Bell: Maybe I could start off using a clinician's voice, Mr. Yurek, speaking to the issue of drugs that are currently prescribed on private plans that are not on our formulary. We've looked at every one of those. Some of them are quite extraordinary, as you know—third-generation cephalosporins being prescribed for seven days for acute sore throats and things that are entirely inappropriate. Of course, there are many drugs that have equivalents on the public drug plan that are not covered by our plan, but certainly have therapeutic substitution opportunities.

What we're really concerned about most are the chronic drugs that may not be on our program, for example, epilepsy drugs and rheumatoid arthritis drugs. We're collaborating with the pediatric specialty groups in understanding where those challenges might lie.

You're quite right that EAP in the past has suffered from a manual process for approvals. We're going to be delighted, in probably the first half of calendar 2018, to introduce SADIE to pharmacies, which will be an online process where a lot of that manual work will be automated. We think this is going to be much easier in the future.

We're not expecting a lot of denials of chronic drugs that are applied for under EAP. Most of those drugs, for things like rheumatoid arthritis and epilepsy, are available under EAP with appropriate limited-use criteria. Most of those are approved for children.

Mr. Jeff Yurek: Thank you. The private insurance plans also have a faster mechanism of bringing new medications to their patients and clients to access them. The Ontario drug benefit is really slow. The pCPA process is extremely slow at bringing in new medications. How are you reforming the system to ensure that those who have private coverage now and have access to up-to-date medications still have that access after January 1?

Ms. Suzanne McGurn: Again, thank you for the question. I think it builds on the questions last week regarding pCPA.

I think there are a number of things under way. One is, we are continuing to work with Health Canada. They are working on regulatory reforms as well, and we are working with the pCPA and CADTH to be able to—for those products that are unique and special and a high value, rather than be addressed in a sequential way, to find ways for those processes to be overlapped and shortened. But for clarity, there will not be a change to the pCPA process. New medicines will continue, as they currently are, to be assessed through an evidence-based approach to ensure clinical and cost-effectiveness for medicines, similar to how medicines are currently made available to seniors and others.

With regard to individual insurers, it is our expectation that they will continue with their employer groups to look at how they will continue to insure, and I think we will see that evolve over the time periods. At the moment, we would expect them to be considering how they will provide support for drugs that are not covered by the Ontario public drug program, much as they do for other age groups at this point in time.

Mr. Jeff Yurek: That's your expectation, but are they listening? Have you worked with them to ensure that the savings they're making are reinvested in the programs?

Ms. Suzanne McGurn: Are we working with them? I can confirm that there is a weekly meet with CLHIA and has been for some time, and that includes representation of a wide range of the insurer groups. I believe it has been stated in other settings that, depending on the type and nature of plan that individual employers have, the savings may be approximately 5% to 10% of the total value and depending on the nature and type of insurance plan, the employers will see immediate and real benefits for those plans where the employer actually pays for the cost of drugs and has the insurer act as a claims assessor, so they will immediately see those changes. For the other types of plans, you will see the impact of the OHIP+ be built into future premium discussions.

I think it's important to recognize, however, that employers have been bringing to the attention of individuals in the drug portfolios over time, for example, the real difficult decisions that they've had to make, where, if an individual or a child of one of their employees suddenly is requiring a very expensive drug or a drug for rheumatoid arthritis and where they've had to make choices about actually giving up their dental benefits, etc., to be able to fund that one individual.

We hope that the space created by the OHIP+ program will allow employers to make different choices or at least be able to see some moderation in their premium growth that they've been experiencing over recent years.

Mr. Jeff Yurek: Has the government conducted any analysis to determine the financial impact of having OHIP+ being the last payer to fill the gaps of existing private insurance plans that might order more—did you

do analysis of using it as a second payer as opposed to the first payer?

Interjections.

Hon. Eric Hoskins: Sorry, I missed the beginning of that, so I'm going to let Suzanne answer that as well. She's probably best placed anyway.

Ms. Suzanne McGurn: So the question that was asked was, first-payer or second-payer?

Mr. Jeff Yurek: Did you do an analysis to see—

Ms. Suzanne McGurn: What I would say is, what we were asked to do was bring forward recommendations about how to expand universal access to the patient population, and so the approach that we provided was one that was a universal first-dollar payer, as was requested.

Mr. Jeff Yurek: So you didn't look at it as a second payer at all?

Hon. Eric Hoskins: We did. Not so much in a fiscal context, but advocates for pharmacare and many others have always supported a first-payer system, and I think our philosophical approach to look at pharmacare in this province was to build it as part and parcel of our universal health care system. My arguments have always been that we can't look at the provision of prescribed medications any differently than we look at access to emergency rooms, hospitals or a primary care provider. In fact, the evidence demonstrates that a first-payer provision is likely the best way of generating and sustaining public support for the system. We've certainly seen that in universal health care.

0940

I have yet to see an expert or an advocate who has done the detailed work to look at pharmacare—I have yet to find one who hasn't emphasized the importance of a first-payer approach, and that was the approach that we decided to take, understanding that it may have fiscal implications.

On the 45%-55% figure, I don't know if you're prepared to share with us the source of that data. I find it surprising. Maybe it's your own figure. Suzanne has emphasized the close relationship with the insurance industry that we began immediately after this was announced and approved in the budget, and even before it was approved, we obviously began having conversations in a provisional manner.

I'm absolutely confident that the savings, which the industry has provided us with—their sense of what those savings can and will be—will be passed on to employers and employees. We're already seeing that happening. Many of the insurance plans that are out there are cost recovery by the insurance company plus an administrative premium to administer the program, which is paid by the employer. It will be an absolute straight line. As the insurer sees those savings, those savings will be directly passed on to the employer and the employees.

Also, in terms of the logistics, I know you characterized the EAP, the Exceptional Access Program—I would take issue with the way you described it as being overly onerous. It has been tremendously successful in providing access, and that aspect of pharmacare, of OHIP+—

we've been working exceptionally closely—as Suzanne was mentioning, on a weekly basis, we have meetings—with the insurers to ensure that individuals who are eligible for EAP, children and youth who are currently receiving that through their private insurance—that it will be a seamless transition into OHIP+ on January 1.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have just over two minutes.

Mr. Jeff Yurek: Two minutes? Thanks.

We'll gladly show you our data as soon as you guys answer all and share the data we're requesting at this committee. I think it's a fair way.

Can you just answer one last question, I guess, in two minutes? Why wasn't the Ontario Pharmacists Association consulted in the development of OHIP+ and why weren't they contacted until months after the announcement, considering they're the ones who actually deal with providing the drug plan to Ontarians in this province and have the expert advice on what's best for the system?

Hon. Eric Hoskins: As you're familiar with the normal budgetary process, it is generally not the case that consultations take place, certainly not in a formal context and often, particularly on sensitive issues, not informally prior to the budget itself being tabled. That was the case with OHIP+. I think we can all imagine that there were many reasons, including proprietary ones, why it was important that we maintain, as is normal for the budgetary process, absolute secrecy.

I'll let Suzanne talk about the consultations that took place, particularly with OPA, in the subsequent months.

Ms. Suzanne McGurn: Again, thank you for the question. I would just comment that we do have very regular contact with OPA and NPAC, so both of the organizations that represent pharmacists and/or pharmacies or both in the province. Certainly they are able to reach out to us.

Many of the questions that are of critical issue to a pharmacist on the front line are quite operational. Certainly it has taken us time to be able to work through some of the circumstances with the insurers to be able to provide the level of detail etc. Again, the time to launch OHIP+ is short, and what we've been trying to do is make sure that we're reaching out and getting all of the questions as much as possible.

The OPA has provided valuable insight, as has NPAC, about things that are important to their members. We've engaged other—

The Chair (Ms. Cheri DiNovo): I'm afraid, Mr. Yurek and the ADM, the time is up. We now move to the third party: Mr. Tabuns.

Mr. Peter Tabuns: Good morning, Minister, Deputy Minister. Before I go to my questions, I have a statement that I'd like to bring forward. Very simply, there is an overcrowding crisis inside Toronto's hospitals. Eighty-five per cent occupancy is considered safe by international standards like the OECD and by our own Auditor General. In the Auditor General's 2016 annual report, she said, "There is much research to show that occupancy rates higher than 85% not only result in longer wait times

for hospital beds in acute care wards, but also increase the risk of transmitting infectious disease." But the reality is that Toronto's hospitals are being forced to operate far above the 85% safe occupancy rate.

Here's what the overcrowding crisis looks like in Toronto's hospitals: SickKids operating with occupancy up to 107%, with mental health beds reaching as high as 136%; Etobicoke General Hospital, as high as 122%; Toronto east Michael Garron Hospital, as high as 106%; University Health Network, up to 98%; Humber River Hospital, operating with up to 97 unconventional beds in February 2017.

This crisis isn't about a coming surge due to a bad flu in Australia, although that is something we should be preparing for. This is about hospital capacity and resources being systematically cut in Toronto's hospitals by this Premier and by the Conservatives before that. People in Toronto, people in my riding, are suffering because of this government's hospital cuts.

My first question is to the minister: Have you ever visited a hospital in Toronto and actually spoken with one of the hallway patients who are placed in an unfunded overflow bed?

Hon. Eric Hoskins: As you can appreciate, I've had many visits to hospitals across the province in the course of my work. The announcement that I made just over two weeks ago speaks to the government's response. In addition to the nearly 1,000 new beds that have been created in this province over the past, I believe, four or five years, we announced an additional 1,200 acute care beds—in-patient beds in conventional spaces—that will be allocated, including a significant number of those in Toronto.

Mr. Peter Tabuns: Minister, in fact, then, you haven't talked to someone in a hallway who's waiting for care.

Hon. Eric Hoskins: As part of my work, I have many conversations with many individuals: patients, volunteers, caregivers and front-line health care workers. When it comes to Toronto, we work extremely closely with our hospital partners, and that's been reflected in the increase in the operational budget this year as well as the specific allocation that formed part of the announcement that I made two weeks ago.

Mr. Peter Tabuns: I take it that you haven't had such a discussion. I'll move to my next question. Why is it acceptable to you to force Toronto's hospitals—world-class hospitals—to operate with occupancy rates over 100%?

Hon. Eric Hoskins: Well, as you can appreciate, the occupancy rate of our hospitals varies substantially across the province, and it reflects a whole variety of circumstances. It reflects the availability of suitable resources out of hospital for alternate-level-of-care patients to be transferred out of hospital and make beds available. It reflects the growing and aging population, as well, in terms of the pressures for increased volumes of patients being seen and increased complexity.

Working very closely over the course of the past number of months with the Ontario Hospital Association

has led us to, as I have mentioned—in addition to the \$1 billion over two years in new funding for the operation of our hospitals and the nearly 1,000 new beds created over the past—I'll just say over the past five years to be safe—we announced this additional allocation, which was done in partnership with the OHA, of 1,200 additional acute care beds.

I believe that that is not only a highly substantial quantum in terms of the level of investment, but when you add that to the nearly 600 transitional beds which we also announced, including a number of those in Toronto at the Hillcrest site of University Health Network as well as at the Finch site of the ex-Humber River Hospital—well, it's still owned by Humber River Hospital, but the former Finch hospital site—to allow us to decant or transition individuals who no longer require acute care out of hospital to more appropriate settings where they can get that highly specialized care—it's those steps, but most importantly, I think, working in close partnership with our hospitals and with the staff within them that has led us to these investment decisions.

0950

Mr. Peter Tabuns: The deputy minister has told this committee that the ministry collects occupancy data on a daily basis at midnight and data on how many patients are admitted in the emergency department, which is also collected daily.

Will you, Minister, table this information with this committee for all Toronto hospitals, and will you do it before estimates hearings are completed so that we can actually discuss it with you?

Hon. Eric Hoskins: I'm happy to look into that.

Mr. Peter Tabuns: So that is a commitment to tabling it before the estimates are done?

Hon. Eric Hoskins: I'll certainly discuss that with the ministry.

Mr. Peter Tabuns: Minister, SickKids has 42 physical neonatal intensive care unit beds, “but the ministry only provides funding to staff 34 of them,” according to the Toronto Star. Your announcement on October 23 adds two additional NICU bassinets for SickKids, for a total of 36 funded bassinets, and that’s good news. I’m glad that there’s more funding. But the problem is that during summer months alone, SickKids has been treating between 38 and 40 NICU babies every day.

SickKids is one of the best children’s hospitals in the world. They clearly need at least 40 beds staffed in the NICU, if not the 42 they physically have. Why are you not funding them properly?

Hon. Eric Hoskins: I think, as you can appreciate, particularly in a city like Toronto, when we’re discussing neonatal intensive care, our requirement and our objective is to ensure that individual hospitals have the requisite amount, but also that we also have a network which functions effectively. For example, across the road at Mount Sinai, we’ve added—how many?

Dr. Bob Bell: Four.

Hon. Eric Hoskins: Four—I think even two additional neonatal intensive care beds at Sunnybrook and four at

Mount Sinai for a complement of eight within the city alone. We believe that that is not only an important but an appropriate investment. In the summer, there was a challenge, the causation of which has not been determined, that led to the capacity challenge, but that has dissipated. We believe that this investment on a go-forward basis is appropriate.

If you’ll allow me, just in terms of the September midnight bed-census reports, SickKids was under 100% capacity, St. Mike’s was under 100% at 94% and Michael Garron was at 80% capacity.

Mr. Peter Tabuns: Thank you, Mr. Miller.

Mr. Paul Miller: Good morning, Minister. I’m just going to give you a background—

The Chair (Ms. Cheri DiNovo): Mr. Miller.

Mr. Paul Miller: Oh, thank you, Chair.

Good morning again. I’m just going to give you some background on what’s going on in Hamilton, and then maybe you can answer the questions.

I guess 25 surgeries were cancelled or postponed in the past month because there were no beds: 16 at St. Joe’s and at least nine at Hamilton Health Sciences, and a staggering 121 unfunded overflow beds were operating some days. On October 10, 121 unfunded overflow beds were operating at Hamilton Health Sciences—that’s a new record, Minister—beating last year’s record of 113. That number does not include the number of admitted patients waiting in the emergency rooms, which is an average of 44 per day in October. The fact is that hospital cuts are having a devastating impact on people in Hamilton.

On Saturday, the Hamilton Spectator released the following revelations: St. Joseph’s Healthcare Hamilton had 26% more patients than medical beds in August. Across the city of Hamilton’s hospitals, an average of 86 overflow beds, some in hallways, sunrooms and other totally unconventional and inappropriate spaces, were operating every day in September. These beds are not funded by the province, and do not include patients crammed into emergency departments.

September mornings started off with 51 patients on average stuck in Hamilton’s adult emergency departments waiting for a bed to open. Hamilton Health Sciences has not been below 100% occupancy for 14 months in its adult surgical medical wards. Juravinski has been running at 110% occupancy or higher.

Real people in Hamilton are suffering, Minister, because of the crisis of hospital cuts, overcrowding and hallway medicine. We know that you announced additional temporary beds for the remainder of the fiscal year, until March 2018, on October 23, 2017. Additional beds are welcome; however, it’s not nearly enough. It won’t fix the crisis that the government has created.

The numbers tell the story. An additional 54 temporary adult beds will not solve a problem that sees 121 unfunded beds operating at Hamilton Health Sciences. It barely scratches the surface of this crisis, Minister. Basically, I’ll ask you some questions now, if you’re not distracted.

Hon. Eric Hoskins: I'm listening intently.

Mr. Paul Miller: Why have you forced Hamilton Health Sciences to cut \$120 million since 2011 and why are you forcing Hamilton Health Sciences to cut an additional \$20 million this year, while St. Joe's health care is forced to cut another \$7 million this year?

Hon. Eric Hoskins: Well, first, we haven't been cutting Hamilton Health Sciences at all; in fact, this fiscal year we gave them an increase of over \$16 million for their operational activities. I'm glad that you support our decision to invest in roughly 1,200 new acute care beds across the province; and that includes, importantly, Hamilton. The Juravinski site of Hamilton Health Sciences is receiving 15 additional acute in-patient beds, as per the allocation; the Hamilton Health Sciences general site at McMaster is receiving 15 additional acute care in-patient beds—

Mr. Paul Miller: Minister, will all due respect, this information comes directly from the bureaucracy of the hospitals. Obviously we have a difference of opinion in what you're saying is happening and what they're saying is happening. These are straight from the hospitals in Hamilton. What you think you've done—

Hon. Eric Hoskins: Yes, but you're asking me about overcrowding, I'm telling you about the response—

Mr. Paul Miller: And you say there is no overcrowding?

Hon. Eric Hoskins: No, I'm telling you what the government is doing to make sure that there is capacity within the hospital system, particularly in Hamilton, which is the basis of your question.

Mr. Paul Miller: They're over 100%, Minister, in every hospital in Hamilton.

Hon. Eric Hoskins: So Hamilton Health Sciences: the McMaster site, 15 additional beds; the Juravinski site, 15 additional beds; 3 additional NICU—neonatal intensive care—bassinetts at Hamilton Health Sciences; St. Joseph's, 24 additional in-patient beds. And we have an additional set-aside of 65 beds which are as yet unallocated.

Mr. Paul Miller: Minister, do you realize—and I'm sure you do, being a physician—that, next to Toronto, Hamilton is the cancer centre for all of Canada, pretty well. We don't just service people in Hamilton. We service people from all over the province. I don't know what your numbers are based on, but we get influxes monthly from other unexpected sources that come into Hamilton on a regular basis. The dent you have made is minor. It's not going to cover what we need in Hamilton.

It's a huge cancer centre, as you know. We've had reports in the papers in the last few weeks that are just devastating, some of the families, as you've heard in question period. I don't know what you're basing your facts and your numbers on. You may quite well have opened those beds, but it doesn't nearly come to what we need in there. We are a major centre, and major traffic goes through Hamilton that maybe you're not taking into consideration when you're opening these minuscule amounts of beds, because it's really bad.

And—

Hon. Eric Hoskins: Will you allow—can I respond to that?

Mr. Paul Miller: I guess you yourself have visited Hamilton Health Sciences, I'm sure, and—

Hon. Eric Hoskins: I've not only visited, but I graduated from Hamilton Health Sciences.

Mr. Paul Miller: If you had actually—okay. Have you ever actually spoken to the people who are in the hallways? They're there every day. I have seen it myself, Minister. I've gone there. The people actually placed in overflow unfunded beds are numerous. And it's not just a weekly thing; it's a daily thing. What do you say about that?

Hon. Eric Hoskins: As I mentioned, I've visited Hamilton Health Sciences. I graduated as a physician from Hamilton Health Sciences' medical school at McMaster.

We have an allocation for Hamilton Health Sciences of 33 beds and an additional set-aside for that LHIN of 65 spaces—and, additional to that, transitional spaces, as I mentioned earlier to your colleague, to pull ALC patients out of hospital, to make additional capacity available. We've been working very closely with the CEOs of both hospitals, St. Joe's and Hamilton Health Sciences, as with the OHA. It was important to us, because in some cases the allocation reflects the available space and the beds that can be made available over a short period of time. It was important to us that these beds be made available and active within a number of weeks.

Mr. Paul Miller: Thank you. Just one last question. In question period, this certainly gets hot and heavy at times, and certain individuals have said that some of our remarks are bogus. Well, I really am offended by those comments, because these are people—I'm talking front-line nurses, front-line doctors, front-line bureaucrats, front-line management—who are coming and complaining to us. So I don't know what they're saying to you, and whether they're being sweeter and they expect that maybe you're going to open the purse strings—I don't know—but these things are happening every day.

1000

It's realistic. It's not a fantasy. We're not making up these things. We don't come for political reasons to complain about this. I have friends who have gone through problems in the hospitals there because of lack of funding, lack of beds, and that's coming from here, not from here. I'm telling you that things are bad in Hamilton.

Yes, you've addressed a small part of it, but it's nowhere near where you have to go. Are you planning on putting more beds in there? Are you planning to visit us more? Why don't you sit down with the management, us, and the nurses and the doctors? Maybe they're afraid to come forward because of funding problems and they figure they'll get cut off; I don't know. But the stories we get are a lot different than what you're telling, so somebody is pulling a string—or I don't know what's going on over here.

Hon. Eric Hoskins: First of all, in terms of what was said in the Legislature, I certainly appreciate the com-

ments that you're making now. They're provided in good faith. I don't believe you've had the opportunity to ask me questions in the Legislature about the hospital system.

Our response, the 2,000 beds and spaces, including the transitional spaces and affordable housing for seniors, particularly when it comes to the approximately 1,200 acute care beds in hospitals, came through an exercise that was taken by the OHA, the Ontario Hospital Association themselves, where we reached out to them to better determine the nature of the challenges that were being faced by the 150-plus hospitals and asked them to provide us with that inventory and those opportunities for funding. We've responded to that.

Again, in the case of Hamilton, we have a significant number of spaces, as I mentioned: 33 at Hamilton Health Sciences and 24 at St. Joseph's—

Mr. Paul Miller: Minister, with all due respect—

Hon. Eric Hoskins: Yes?

Mr. Paul Miller: The demographics in Hamilton have changed. I have 2,000 new families in my riding alone, down by the lake near Grimsby, who are serviced by Hamilton hospitals. Also, what you don't realize and what your government doesn't realize is that Hamilton has become a good spot to go for real estate. A lot of families are coming there. We have an influx of population that you wouldn't believe, that we haven't seen in the whole history of Hamilton.

While that's happening, you require more beds and you require more services. I don't know if the government takes a look at the amount of population that's going in there in the last 10 years. I don't think they take that into consideration.

Hon. Eric Hoskins: We certainly do. Capacity planning is important. That's one of the reasons why we've provided Hamilton Health Sciences—

Mr. Paul Miller: Then why have we got a problem?

Hon. Eric Hoskins: That's one of the reasons why we've provided Hamilton Health Sciences this year with a planning grant to look at future capacity—

The Chair (Ms. Cheri DiNovo): Mr. Miller, you have two minutes.

Mr. Paul Miller: Okay. You keep saying the numbers, and that's spread out all over Ontario, but I'm saying that Hamilton is—what, the fifth or fourth largest city in Ontario?

Hon. Eric Hoskins: So—

Mr. Paul Miller: And we're having major problems. I'm not talking about all the other hospitals that you've dealt with in Ontario. The smaller communities and whatever you've done there, I'm not privy to that; I really don't know those numbers. But I do know what's happening in my city, and I know that front-line people are coming to me every week with problems.

When we do ask you in the House about these situations and you quote numbers, that's fine. They're probably true, the numbers you've quoted, but they're not spread out enough. You're not focusing on the needs in a larger centre like Hamilton, and that's the problem we've got. You're well aware of that.

Hon. Eric Hoskins: That's exactly why we targeted the investments, the roughly 2,000 beds and spaces we—

Mr. Paul Miller: The 52 beds in Hamilton aren't even going to dent it.

Hon. Eric Hoskins: Well, I disagree. It's significantly more than that, first of all. In Hamilton, and Niagara, as well, where there's a significant investment in new acute care beds, but also—

Mr. Paul Miller: You're including Niagara?

Hon. Eric Hoskins: No, I'm not. I'm just saying that in addition to what I just referenced, additionally, there's a significant new investment of new acute care in-patient beds in Niagara. Just because it's part of the same LHIN, I felt it prudent to include that, as well.

We have a significant investment currently in St. Joe's and Hamilton Health Sciences, on top of, as I referenced, the—

Mr. Paul Miller: Minister, did you know that the LHINs are complaining to us too?

Hon. Eric Hoskins: —\$16 million in new funding for Hamilton Health Sciences, plus a planning grant for redevelopment, as we did in the budget, announcing redevelopment projects in not only Hamilton, but also Niagara and—

Mr. Paul Miller: Minister, I can quote numbers all day and so can you.

Hon. Eric Hoskins: I'm not quoting numbers, I'm quoting—

Mr. Paul Miller: I'm talking about realistic—

Hon. Eric Hoskins: I'm quoting reinvestments.

Mr. Paul Miller: What's going on every day, on the ground in Hamilton—every day.

Hon. Eric Hoskins: And I'm telling you the investments that we're making, not only in in-patient beds, but also the investments that we're making in planning and—

Mr. Paul Miller: Not nearly enough.

The Chair (Ms. Cheri DiNovo): I'm afraid, Mr. Miller, your time is up. We now move to the government side. Ms. Kiwala?

Ms. Sophie Kiwala: Thank you to the minister and the deputy minister for being here today. I just want to finish up the conversation about the opioid crisis and talk a little bit about your responses to that.

I would like to take the opportunity to acknowledge some work that's being done in our community through Street Health and the capital investment that you provided a couple years ago to make sure that Street Health was up and running in a sufficient and appropriate site, both for staff and for clients of that organization. They've done a great job and they're well-placed now to respond to the opioid crisis in Kingston.

You also talked a bit about the supervised consumption sites. When I think about Street Health, run by Kingston Community Health Centres, as well as the supervised consumption sites across the province, I'm thinking about health care in a more systemic way. It is a system. Health care is a system and it needs to be viewed as such.

I have to say as well that I appreciate the new legislation, the patients first legislation, and that patients are at the centre of care. I know that's a concept that's very important to you. It's very important to me as well.

I just want to also make a comment on what the member opposite has said regarding your interaction with patients and say that I personally have seen you interact with patients, both in Providence Care Hospital in Kingston and the Islands—we also toured through the emergency area in Kingston Health Sciences and Kingston General Hospital. So I know and I've seen with my own eyes—and I know that there's evidence all over social media that you are very much interacting with patients all across this province. So I appreciate your approach. I have seen you always go to patients when we are in those venues. I know that it means a lot to you, and it means a lot to me as well.

With that patients-first focus and with that inclusion in a system of health care, trying to make sure that patients are included in that concept, I know that you created the Patient and Family Advisory Council and that you have just actually appointed the chair of that council. I'm wondering if you can outline what the council will be doing and what impact this will have on health care for Ontarians in the province.

Hon. Eric Hoskins: Thank you. That's a very important question. If I can, I should add—how many minutes are left, Chair, roughly?

The Chair (Ms. Cheri DiNovo): You've got about 17, 16.

Hon. Eric Hoskins: Thank you. It was a great opportunity and privilege to be in Kingston—last Friday; correct?

Ms. Sophie Kiwala: Yes.

Hon. Eric Hoskins: I had the opportunity to more fully recognize the hard work that you had put into the revitalization and redevelopment efforts of Kingston General Hospital, the Kingston site of what is now a health sciences network comprising that and adjacent facilities.

We were able, together, to announce a multi-hundred-million-dollar project that will result in much-needed updates to that remarkable, but aging, facility. I think it is providing exceptional care, but this investment, which I know has been your heart and soul since before becoming an MPP, let alone after—this investment and redevelopment are going to make such a tremendous difference to the roughly half a million people who depend on health services in and around Kingston on an annual basis. It was a real privilege to be there and be part of that announcement and to meet patients and volunteers and administrators, and front-line health care workers as well, who are making a difference in so many lives on a regular basis.

1010

I know that Jillian Paul, who's our director of our innovation branch and health system quality funding reform, is going to be able to speak to this in some detail in a few minutes, but I want to touch on what you refer-

enced near the end, which was our Patient and Family Advisory Council.

Very shortly after becoming health minister, I began to articulate what I felt was a shared vision within the health system for putting patients first. We made some important changes. We developed an action plan, which was promulgated across the system as well, which spoke to the different parts of the health care system and how patients and clients and family members and caregivers and care partners and advocates can and need to be a bigger part of the entire health system process.

I look at it in an overly simplistic way, perhaps, but I imagine it looking down the other end of the telescope. Instead of thinking about programs and services, we think about the experience of the patient or the client and how we can provide services that have the greatest impact on outcomes, the best patient experience and the most seamless experience as well, the most coordinated experience. When you have that as your starting point, the deliberations and the decisions, let alone whom you involve in the deliberations and the decisions, can look quite different, as opposed to taking an approach through the opposite lens, which is, again, focused on developing programs and services.

That patients-first approach is not particularly complicated. There are leaders across this province who have integrated it so well into their provision of health care. Kingston General is a perfect example of that.

It's incumbent upon us to not only look at the delivery of care through that lens of the patient but also involve patients and, as I mentioned, clients and caregivers and care partners and family members and others at every step, so—

The Chair (Ms. Cheri DiNovo): Minister, you have just over two minutes until recess time.

Hon. Eric Hoskins: That was a quick—okay, it's 17 minutes—

The Chair (Ms. Cheri DiNovo): Total.

Hon. Eric Hoskins: —total. Thank you.

We've been integrating that at every level. We're requiring our LHINs, for example, through the Patients First Act, to have a patient and family advisory committee or council within the LHIN itself. Our hospitals have to have the same. That wasn't the case a couple of years ago uniformly across all of our hospitals, but it is now.

I felt it was critically important at the level of the minister as well to have, directly reporting and interacting with the minister—myself, currently—a patient and family advisory council so that I could benefit and the ministry could benefit directly from their advice and insight and they could have input into virtually every policy decision that evolves and gets implemented by the ministry so that we can get this right.

Julie Drury from Ottawa, who has heartbreaking but critically important experience managing her own daughter's complex needs but also a lot of practical experience as a care coordinator and medical advocate, is our first chair of the Patient and Family Advisory Council. She will have with her, in total, 15 individuals who represent

not just patients but people with lived experience—clients, family members, advocates—who, on a regular basis—and I think their first meeting is going to be this coming month; she was appointed over the summer—will be able to provide that deep deliberation and advice and insight on everything we do in health care.

It's a pretty simple idea, but it's fundamentally important. This isn't the government's health care system; it belongs to the people, and the people need to be involved in decision-making at every point of it.

Chair, I think, with that, I probably have 30 seconds left to simply—

The Chair (Ms. Cheri DiNovo): Fifteen.

Hon. Eric Hoskins: —15 seconds left to say that my 12-year-old son is not happy about the fact that I'll likely be here till 6 o'clock tonight, on Halloween, but nonetheless I of course take these discussions very, very seriously.

The Chair (Ms. Cheri DiNovo): This committee now stands recessed until 3:45 this afternoon.

The committee recessed from 1015 to 1558.

The Chair (Ms. Cheri DiNovo): Good afternoon, everyone. We are now going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of 10 hours and six minutes remaining.

When the committee recessed this morning, the government caucus had 10 minutes remaining in their rotation. Who do we have up? Ms. Hoggarth, the floor is yours.

Ms. Ann Hoggarth: Thank you, Chair.

Minister, I know the government is making it easier for Ontario residents who have long-term physical disabilities to access support for personalized assistive devices. The Assistive Devices Program is one of the most generous programs of its nature in all of Canada and is universally accessible to all Ontarians with a valid Ontario health card.

Since 2003, funding for the ADP has increased by 113% to approximately \$463.2 million, and as a result, an additional 150,000 clients have been reached. The Assistive Devices Program supports Ontario's Patients First action plan by supporting seniors and people with disabilities to stay healthy and stay at home for longer, reducing the strain on hospitals and long-term-care homes.

Could the minister provide this committee with details on the mandate of the ADP and advise what devices are eligible for funding assistance?

Hon. Eric Hoskins: I'd be happy to. I'm joined on the far right by Patricia Li, who is the assistant deputy minister for direct services in the Ministry of Health. Patricia and her team have done and are doing such an exceptional job when it comes to the ADP. You're right that, in fact, 60% of those who utilize the Assistive Devices Program are seniors. Many of them and others are those with complex conditions. It really is a program that all of us, I think, as Ontarians should be proud of in terms of its breadth: more than 8,000 devices and supplies are avail-

able, everything that ranges from home oxygen to respiratory equipment, insulin pumps, orthotic devices, prosthetic devices, ostomy supplies, hearing aids, wheelchairs and walkers. So it's an incredibly important program.

I'd like to let Patricia spend a few minutes to go deeper and describe what I'm not only proud of as a program—but I'm particularly proud of the ministry's hard work in developing this to the point where we have—because, in many places, we survey the clients of this program. We have, I think the latest is, a 94% satisfaction rate from clients, which is pretty remarkable when you think of the challenges that people face. Unless you're on Ontario Works or disability, where you have 100% of the cost reimbursed, it's at 75%. So to attain, for something as complex and wide-reaching as ADP is, a 94% satisfaction rate through surveys, I think, is remarkable. It's a testament to the hard work of Patricia and her team. So Patricia, over to you.

Ms. Patricia Li: Thank you very much. I'm Patricia Li, assistant deputy minister for the direct services division of the ministry.

Thank you for giving me this opportunity to speak about the Assistive Devices Program. I know that both the member and the minister spoke about the content of the program. It was started in 1982. Believe it or not, it has been 35 years that the program has helped Ontarians with long-term disabilities, focusing on seniors and children predominantly. I think that it does improve their quality of life and support their ability to live and also work independently in their homes and the community.

You asked about the mandate and some of the program details. I think, first of all, it does associate itself, as you mentioned, with Patients First: Action Plan for Health Care by assisting seniors and people with disabilities, allowing them to stay healthy and stay at home longer. It also really helps our modernization-of-home-and-community-care strategy by focusing on investments to keep people out of costly settings such as hospitals and long-term-care facilities so that they can stay home as long as possible. It does reduce the strain on the acute care system and help reduce alternate-level-of-care status. More importantly, it is one of the key drivers to removing barriers for people with disabilities to employment by making assistive devices more accessible. It helps people with disabilities to use their skills in the workplace to the fullest.

I wanted to talk about some of the aspects of the ADP program. It is the most comprehensive program across Canada in the context of accessibility, patient choice and being patient-centred.

In terms of accessibility, the funding is available to a broad range of patients with different needs and abilities. You mentioned the eligibility criteria. One of the things that we also do in a jurisdictional survey across Canada is—in other jurisdictions, they add more eligibility criteria: income-based and also age criteria, which we do not have in Ontario.

We also support a large number of patients, as you mentioned. This year, we're investing \$478 million in the

program, which will serve over 350,000 Ontario residents and certainly serve some of the most vulnerable patients with the highest needs.

In terms of patient choice, we provide over 8,000 different devices in 19 categories, including the ones that you mention. Our Home Oxygen Program is the most popular amongst the senior community. The system currently includes multiple vendors across the province, allowing for broad patient access and choice. The overarching mandate of the delivery of our programs is really trying to provide that patient-centred care.

I also wanted to talk a little bit about that we actually have achieved a 94% patient satisfaction rate—and we do a survey every two years. We have continuously improved our satisfaction rate from about 85% five years ago to 94% in the most recent survey.

The service delivery structure requires the ADP to work very closely with health care professionals and vendors. It has a vast network of more than 5,400 health care professionals—for example, physicians, occupational therapists and respirologists—who identify treatment options and authorize eligibility.

We also work with over 18 vendors to provide devices and service supports to Ontarians, which is more unique to Ontario. I think with our vendor community, we ask them and expect them, through our agreement, to embrace three key service principles. They have to provide patients with high-quality customer service; offer appropriate advice based on client needs and circumstances; and ensure appropriate geographical access and provide the device in different care settings. Those are very important and we actually build that into our vendor agreement.

We are very conscientious about the time frames in order to meet the patients' needs. We do have a six- or eight-week service standard, but we are trying to improve that through investment in technology. We have actually invested a lot in technology, both for automatically approving patients' claims and also improving access by vendors to the billing system so that it accelerates the receipt of their billing requirements.

We also try to include technology as part of the product offerings by working through partnerships with groups such as the Ontario health technology assessment committee. Through the Ontario Health Coalition, we get advice on new technologies that should be considered for public funding. This will ensure new technologies will be based on market analyses and leading practices that are evidence-based. This helps government to determine which devices should be funded publicly, as they provide benefits to the patient and are cost-effective.

Through our ministry's work on vendor management and price reviews, we were able to, in the past years, save \$50 million through price reduction for mobility devices. This actually means a patient doesn't have to pay over \$400 for a wheelchair, depending on which type.

The Chair (Ms. Cheri DiNovo): Ms. Hoggarth, you have one minute.

Ms. Patricia Li: Sorry?

The Chair (Ms. Cheri DiNovo): One minute.

Ms. Patricia Li: In conclusion, the ADP is an example that puts patients first, as they receive the devices they need to improve their quality of life and support their ability to live and work independently in the community. Thank you very much.

The Chair (Ms. Cheri DiNovo): We now move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: To the minister: Could you inform the committee how much money the government will be spending to start the new PSW registry?

Hon. Eric Hoskins: If you'll give me a moment—it's \$2.1 million.

Mr. Jeff Yurek: And what would be the annual cost to maintain it?

Hon. Eric Hoskins: I'm sorry, I'm looking for it. I don't currently have that before me.

Interjection.

Hon. Eric Hoskins: The estimate is \$2.1 million annually.

Mr. Jeff Yurek: Was the Ontario PSW Association proposal considered for the registry?

Hon. Eric Hoskins: Yes, it was considered.

Mr. Jeff Yurek: And how much funding is the Michener Institute receiving for the registry?

Hon. Eric Hoskins: The full amount will go to the Michener Institute.

Mr. Jeff Yurek: What is SEIU's role in the registry?

Hon. Eric Hoskins: None. They have no role.

Mr. Jeff Yurek: What happened to the data that was accumulated from the last PSW registry when it was scrapped?

Hon. Eric Hoskins: That data was—my recollection is that it was archived initially. HealthForceOntario was given the data, I believe, to archive it. But perhaps we can go to the source to get the most accurate data possible.

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Dr. Bob Bell: I can introduce director Allison Henry from our health, human resources and regulation area.

Ms. Allison Henry: The data is currently archived. It's not going to be part of the new PSW registry. It was not credible data, and it would not be helpful to the rebuild of a registry. We had some challenges with respect to validating individuals in terms of their education, training and competence to practise, and it was not felt that it was data that could be shared and/or migrated to a new registry.

Mr. Jeff Yurek: That data was never shared with anyone; it was just archived?

Ms. Allison Henry: That's correct.

Mr. Jeff Yurek: Could you let us know what the budget is for the new caregiver organization that you announced on October 5?

Hon. Eric Hoskins: I'm sure we can.

Interjection.

Hon. Eric Hoskins: I'm told approximately \$1.3 million this fiscal year, growing to approximately \$2.5 million annually for what will likely be known as Caregivers

Ontario. I'm happy to describe the myriad of supports that it will provide to caregivers across the province.

Mr. Jeff Yurek: Will this Caregivers Ontario have agencies in each of the 14 LHINs?

Hon. Eric Hoskins: If you are okay with this, we'll ask the officials who are most directly engaged to respond.

Ms. Nancy Naylor: Hi, I'm Nancy Naylor. I'm an associate deputy minister with the Ministry of Health.

I think it's early days in developing the plan for that, but the thinking is that there would be some regional presence, probably co-located with existing agencies—not likely in every LHIN, but some regional reach, for sure.

Mr. Jeff Yurek: So you haven't thought out the full plan of how this organization is going to run?

Ms. Nancy Naylor: We're just developing the business plan, and then we expect that the organization will incorporate as a non-profit entity, establish a board and establish a plan. We're just in the—

Mr. Jeff Yurek: Have you established a board for Caregivers Ontario?

Ms. Nancy Naylor: No.

Mr. Jeff Yurek: No?

Hon. Eric Hoskins: What we have done is—Janet Beed was asked, I guess approximately a year ago, to begin consultations with the sector, obviously, especially with caregivers and those who represent them in addition to others in the health sector and in the broader community, and to look at models in other jurisdictions. This is a relatively new concept, but in eastern Canada they have successful similar models. Her task through that consultation was to provide a set of recommendations to the government, which she did over the summer, I believe. The commitment to establish Caregivers Ontario was a natural product of those consultations and her recommendations.

Having established what the initial funding would be for the entity, we're now in the process of firming it up in terms of its more specific mandate, the governance aspects of it and how it can best support caregivers through a variety of modalities across the province.

Mr. Jeff Yurek: Who did you consult with in the home care provider field?

Ms. Nancy Naylor: Janet Beed, supported by our staff, consulted very widely. She consulted, for example, with Home Care Ontario and the Ontario Community Support Association, with the Alzheimer society, with the Change Foundation and with a number of service provider agencies like Saint Elizabeth and VHA. We could probably find our note that explained all of them, but I think—

Mr. Jeff Yurek: So you met with these agencies this past summer?

Ms. Nancy Naylor: Yes.

Hon. Eric Hoskins: No, just over the course of the last year.

Mr. Jeff Yurek: The last year? Not in the summer?

Hon. Eric Hoskins: Roughly.

Mr. Jeff Yurek: Could you supply a list of who you consulted with to the committee?

Hon. Eric Hoskins: We can certainly look into that.

Mr. Jeff Yurek: My understanding is that these agencies are going to be hiring PSWs.

Hon. Eric Hoskins: The which—sorry?

Mr. Jeff Yurek: This new agency will be hiring, no?

Hon. Eric Hoskins: Caregivers Ontario? No. Caregivers Ontario is intended to be in part an umbrella organization that will interact with existing organizations to provide support to caregivers as well as be sort of a one-stop shop for caregivers, their advocates and others in the health sector to be able to obtain resources, advice and get connected with other resources to promulgate best practices.

The impetus was really to work at recognizing the tremendous value and contribution that caregivers make across the province and across the country. It was really to establish an entity that could serve them and provide them with maximum support—and recognize their value to the system, but making sure that they've got the resources they need.

Mr. Jeff Yurek: Were there two announcements you made that day of what you're organizing?

Hon. Eric Hoskins: Oh, gosh. There might have been. It's hard for me to keep track.

Mr. Jeff Yurek: Let me check something here. Are we talking about the pilot project that you're starting within the three LHINs that's beginning in January? Is that related to Caregivers Ontario?

Hon. Eric Hoskins: Not that I'm aware of, no.

Mr. Jeff Yurek: Okay. I'll just check the announcement here. If you give me a minute.

While I'm looking this up, if you want to provide—the \$100 million you announced to open the hospital beds across the province: Can you let us know where that money is coming from?

Hon. Eric Hoskins: That's within our fiscal plan.

Mr. Jeff Yurek: Within the fiscal plan? Could you let us know where the beds are going to be located?

Hon. Eric Hoskins: That was made publicly available at the time of my announcement a week ago yesterday. Given that there was a subset of those roughly 1,200 acute in-patient beds that have yet to be allocated, the LHIN allocation and the number of beds in that unallocated portion was also part of the backgrounder that was provided publicly at the time.

Mr. Jeff Yurek: These beds that you're opening in the two locations: The Humber hospital, is that the one?

Hon. Eric Hoskins: In addition to the roughly 1,200, there were just under 600 transitional spaces being funded to bring people out of the acute care setting—the ALC patients, the alternate-level-of-care patients who don't require acute care.

The Humber example was the Finch site of the former Humber River Hospital. It's a collaborative proposal of five hospitals in the Central LHIN that have come together, which will allow them to transition—it will be, I think, on an annual basis about 1,700 individuals, about

150 beds in the Finch site. I'm just trying to recall the name that they've—

Dr. Bob Bell: Reactivation.

Hon. Eric Hoskins: The Reactivation Care Centre. It will provide specialized and rehabilitative transitional care and support to those individuals as they pass through it on to their destination, which hopefully, in the majority of cases, will be home or other supportive entities within the community.

Mr. Jeff Yurek: The reopening of the shuttered hospitals: Are they going to be reaccredited? Have we looked at the safety of the environments since they were shuttered and not been used?

Interjection.

Hon. Eric Hoskins: The deputy has just reminded me that they will form part of the Humber River Hospital accreditation process, so yes.

Mr. Jeff Yurek: When will that be undergoing accreditation, and how much will that cost?

Dr. Bob Bell: There is usually a three-to-four-year cycle. I anticipate the next time that Humber is accredited, they will accredit all aspects, as they usually do, of the Humber site.

Mr. Jeff Yurek: So we're going to open that hospital and not have it officially accredited for whenever the next cycle is. Do you know when?

Hon. Eric Hoskins: They'll be fully accountable under the governance of the Humber site, as is the case with hospitals, and presumably with new hospitals that are opened as well. Deputy, I'm not sure, for example, with the Oakville hospital, the Humber River Hospital or the new hospitals, whether they are immediately accredited or if they form part of the normal cycle. I know you would know this as former CEO of the University Health Network.

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Dr. Bob Bell: Yes, that's the case, Minister. There is a regular cycle that doesn't depend on when the hospital is being opened.

Hon. Eric Hoskins: But it means they're no less accountable. The board governance of a particular entity—in this case, Humber River Hospital—is responsible for that ongoing supervision and accountability.

Mr. Jeff Yurek: Okay. Is this funding that you've allotted to reopen these spaces ongoing, or is it a one-time thing and we'll look at it again next year?

Hon. Eric Hoskins: As I've mentioned before here in front of committee, it's typically the case across essentially all government ministries that when in-year allocations are approved by Treasury Board, they're just exactly that: They're in-year allocations.

We have already begun the budgetary process through which we have the necessary conversations with finance and with Treasury Board and, if necessary or ultimately with cabinet, on the allocations for the "out" fiscal years. Obviously this is part of that conversation that has already begun.

Mr. Jeff Yurek: Okay. I think I've found my notes here. Back to the announcement from October 5: You're

right; you did mention a caregiver organization, but you also made mention of a new personal support services organization. Can you let us know about the personal support services organization and let us know how much money is going to create that organization?

Hon. Eric Hoskins: The funding for it? I'm not sure if funding has been established or not.

Interjection.

Hon. Eric Hoskins: I've been told that this year's financial contribution towards that entity is \$2.9 million.

Mr. Jeff Yurek: It's \$2.9 million. And that is the one I'm talking about, with three LHINs?

Hon. Eric Hoskins: Yes.

Mr. Jeff Yurek: So is this support agency going to be created in each of the LHINs, or is there going to be one central Ontario support service?

Dr. Bob Bell: Why don't you come and join me, Patrick?

We're anticipating that this will start up in a smaller number of LHINs and develop in a demonstration fashion and then expand, if successful, beyond the three initial LHINs that it's starting in.

Mr. Jeff Yurek: So this patient support service will be the organization hiring the PSWs?

Hon. Eric Hoskins: They will have a roster of PSWs. To go back: Gail Donner, who gave advice through a task force on home and community care—one of the recommendations that came out of that, perhaps two and a half years ago, was to develop self-directed care models for individuals, clients and their caregivers who felt comfortable having that greater level of control and flexibility. It means that you have greater control over who your PSW is as well as the hours.

We put a considerable amount of time in in terms of what that mechanism would look like, realizing that in most cases—well, for two reasons. Families or individuals didn't want to have the burden of hiring and negotiating contracts and payment, and then from an employee perspective as well, we wanted to make sure that employees were treated fairly and appropriately under the various pieces of legislation that apply to them and protect them.

The model that we landed on I think is the proper one, where a roster of PSWs will be provided through this entity, and then individuals, on a pilot basis, to begin with—certain home care clients will be allocated, based on assessments, a financial equivalent to hours of care—or actually, I think they'll be allocated hours of care, probably, right?

Mr. Patrick Dicerni: Yes.

Hon. Eric Hoskins: Thank you. But they will then be able to access the roster of PSWs of this entity to choose the PSW who they feel is best suited for them. Similarly, they'll be able to determine quite specifically the nature of that relationship from the schedule of work, for example, for that individual.

Mr. Jeff Yurek: Who are these PSWs on this roster? Who are they employed by?

Hon. Eric Hoskins: Currently there are no PSWs employed by this entity, but it is envisioned that they will be employed by the entity at some point in the future.

Mr. Jeff Yurek: So a government entity?

Hon. Eric Hoskins: It is separate from government. It is, I think, a non-share corporation, a not-for-profit corporation.

Mr. Jeff Yurek: Who owns the corporation? Who's going to be in charge of the corporation?

Hon. Eric Hoskins: It will be an independent governing board—right?

Dr. Bob Bell: Yes.

Hon. Eric Hoskins: An independently governed board.

Mr. Jeff Yurek: So it's going to be fully funded by the government, this agency, and there are going to be 14 of them in the province?

Hon. Eric Hoskins: No, I believe there will be one, but it will be accessible throughout the province.

Mr. Jeff Yurek: And then these PSWs will be employed by the agency? How are these PSWs going to be compensated?

Dr. Bob Bell: They'll be compensated by the agency with a transfer payment agreement developed with the agency, appropriate to the number of folks employed and the number of patients who are actually determined by care coordinators employed by the LHINs as requiring care, really focusing on folks who have more complex needs—more chronic needs, for example; people who are anticipated to require more than 14 hours of care a week by PSWs. These would be the kind of folks who have chronic, long-term relationships with PSWs whom we think would benefit and who, we have been advised by Dr. Donner, would benefit from having more engagement in the planning of care by PSWs, but not necessarily wanting to go through the logistics of actually hiring people, arranging to pay their taxes etc.

Mr. Jeff Yurek: Did the government consult with current home care providers on the creation of this agency, or discuss it with them?

Hon. Eric Hoskins: Patrick?

Mr. Patrick Dicerni: I'm Patrick Dicerni. I'm the assistant deputy minister in the strategy, policy and planning division at the Ministry of Health. With respect to consultations related to the agency that the minister and the deputy have just described, our research and the data that we have available shows that in multiple jurisdictions, this type of latitude in terms of scheduling and planning home care services is being requested. We moved on the basis of that knowledge that we had gathered through internal research.

Mr. Jeff Yurek: Have you named a CEO of the board that's running this agency?

Dr. Bob Bell: A chairman of the board? Yes.

Mr. Jeff Yurek: Who's that?

Dr. Bob Bell: Marsha Barnes.

Mr. Jeff Yurek: Would we be able to get some info on Marsha Barnes?

Dr. Bob Bell: She's a former OPS employee. We'll look into that.

Mr. Jeff Yurek: So this agency is a board of the government, so the government will be appointing the board members?

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up, Mr. Yurek.

Mr. Jeff Yurek: It was just getting juicy.

The Chair (Ms. Cheri DiNovo): We now move to the third party, Ms. Fife?

Ms. Catherine Fife: It's a pleasure for me to be here this afternoon to address some of the issues that we're facing in Kitchener-Waterloo on the health care file, particularly around hospital overcrowding. I think that the overcrowding crisis in Ontario's hospitals is hurting families in KW as well.

In my office in Waterloo, we've heard from multiple families on a myriad of issues. Grand River Hospital has been forced to operate multiple units well above safe capacity for over 24 consecutive months, Minister. Between January 2015 and December 2016, Grand River Hospital's acute care, surgery, stroke and oncology beds were operating at above a safe capacity every day, reaching at times as high as 117%. International experts, the OECD and the Auditor General have all said that 85% is the safe capacity limit; anything higher than that poses risks to patients.

The hospital's 66 beds in the medicine units operated above 100% occupancy in 22 of the 24 months, with occupancy reaching as high as 116.9%. The hospital's 56 surgery beds operated above 100% more than half the time, with occupancy reaching as high as 114.4%. The hospital's 22 beds in the stroke unit operated above 100% occupancy in 17 of the 24 months, with occupancy reaching as high as 108%. Finally, the hospital's 20 oncology beds operated above 100% occupancy in 12 of the 24 months, with occupancy reaching as high as 110%.

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You can see that there is a pattern of this hospital always being in a state of crisis at a higher occupancy rate, where care is potentially compromised. I ask you: Why is it acceptable for you, as the Minister of Health, to see that Kitchener-Waterloo hospitals, like Grand River and St. Mary's, continually operate with occupancy rates over 100%?

Hon. Eric Hoskins: Thank you for the question. Of course, I'll take issue with your description of the hospital being in a state of crisis—I disagree—or that care is being compromised, as you characterize it. I disagree with that as well.

I have the capacity figures in front of me for Grand River Hospital from April through to the end of September. At no time during those months—Grand River, for each of those months, was under capacity. It was never above 100%—

Ms. Catherine Fife: Are you challenging our FOI results?

Hon. Eric Hoskins: No, I'm just telling you that the figures that I have are from April to September of this

year. For each of those six months, Grand River Hospital has been below capacity—

Ms. Catherine Fife: Is it possible that I could get that data from you, Minister?

Hon. Eric Hoskins: I can certainly discuss that with the ministry.

Ms. Catherine Fife: Thank you.

Hon. Eric Hoskins: With respect to Grand River as well: They were part of the announcement that I made a week ago yesterday, when we announced the 1,200 additional acute care in-patient beds. Grand River has received an additional seven acute in-patient beds as an allocation. The LHIN as a whole is receiving an additional 67 beds. In total, the LHIN is receiving 67. We have unallocated, as of today, out of that 67, 22 beds which still have yet to be allocated. So there is opportunity for Grand River as well as other hospitals to receive additional beds.

That, of course, is in the context of a 2.5% increase in their budget this year, or \$5.5 million in additional operating funds.

Ms. Catherine Fife: Are you aware that at St. Mary's hospital—and I actually came by this knowledge through personal experience when my husband was admitted by ambulance to St. Mary's—the region of Waterloo funds a hallway nursing position? This has been a position in place now for almost three years.

Interjection.

Ms. Catherine Fife: Her position is hallway nurse. It was a 12-hour shift that was funded by the region to help with the off-loading of ambulatory patients. It was the best focus group I've ever participated in, but it was an uncomfortable day to be in the hallway for seven hours. But her shift had actually just been reduced to 10 hours.

This is a region-of-Waterloo-funded position to ensure that ambulatory services can remain—they can drop off their passengers. Were you aware—

Mme France Gélinas: Ambulance, not ambulatory.

Ms. Catherine Fife: Ambulance, sorry—that ambulance paramedics can drop off the patients. Were you aware that this is happening at St. Mary's hospital?

Hon. Eric Hoskins: Sorry, what's happening?

Ms. Catherine Fife: That the region of Waterloo is funding hallway nursing positions at St. Mary's hospital. It's not a provincial expenditure.

Hon. Eric Hoskins: No, it is. I know that the ministry is funding, in many hospitals across the province, specifically in their ERs, off-load nurses who work with our first responders—

Ms. Catherine Fife: Her position is a hallway nurse.

Hon. Eric Hoskins: Well, what it's called is one thing, but I know that we are, across the province, investing close to \$100 million—if I'm not incorrect; I'm happy to correct that figure if I am wrong—a significant amount of money specifically for off-loading in our ERs across the province.

Dr. Bob Bell: If I may, Minister?

Hon. Eric Hoskins: Perhaps the deputy can shine some more light on that as well.

Dr. Bob Bell: That is one component of funding that we provide to emergency departments—P4P, pay-for-performance funding that actually encourages hospitals to make investments in their emergency departments.

One of the elements that we do fund is ambulance off-load nurses. The reason why they might be considered to be hallway nurses is that they will often, when they're not off-loading ambulances onto stretchers, look after patients who are waiting for admission—

Ms. Catherine Fife: In the hallway.

Dr. Bob Bell: Well, in part of the emerg. It may be outside a room; it may be inside a room: patients might be waiting seven hours after the decision has been made to admit them to have a bed come available while patients are being discharged from floors inside the hospital.

Ms. Catherine Fife: And can I just clarify: You mentioned that the budgetary cost is \$100 million?

Hon. Eric Hoskins: Specific to the nursing component for dedicated off-load nurses, it's \$16.1 million. But I have to point out, as well, that in terms of the ER off-load times in terms of minutes, St. Mary's General Hospital is significantly below the provincial average on off-loading of patients.

Ms. Catherine Fife: And so what is that average?

Hon. Eric Hoskins: Thirty-four minutes.

Ms. Catherine Fife: Thirty-four minutes? Oh, that's not bad. Really? That's not bad.

Hon. Eric Hoskins: It's significantly below. You can appreciate that there's a significant amount of work that is entailed from the point of arrival of paramedic services to full discharge, and handing over to the off-load or other nursing staff. But St. Mary's hospital, as well, it's important to point out, for the same six months, they have been under capacity for each one of those six months.

Dr. Bob Bell: Another thing to be clear about is that 34 minutes does not represent a high-acuity patient who requires immediate emergency service. Patients are triaged by EMS into categories: CTAS—Canadian Triage and Acuity Scale—scores I through V. If the patient was a CTAS I patient, they'd be brought immediately into a resuscitation room.

Ms. Catherine Fife: Well, the EMS workers that were dropping patients off to the hallway at St. Mary's hospital were definitely stressed by having to leave these patients in the hallways, as was the hallway nurse, who just happened to be a former student of my husband's. I can tell you right now that it's not an ideal situation.

I only have time for one other question. I do want to reference that the deputy minister has told this committee that the ministry collects occupancy data on a daily basis at midnight, and data on how many patients are admitted in the emergency department, which is also collected daily. I do want to ask: Will the minister table this information with the committee for Kitchener-Waterloo's hospitals, and will you do it before the estimates hearings are completed so that we can actually discuss it with you, as you have called our FOI data into question?

Hon. Eric Hoskins: Well, I haven't called your FOI data into question. I've given you, I think—

Ms. Catherine Fife: You challenged it. You didn't accept it.

Hon. Eric Hoskins: No, I didn't. That's not accurate. I think I gave a different time frame of capacity. I think you referenced data that preceded the—

Ms. Catherine Fife: So you questioned the time frame of our FOI?

Hon. Eric Hoskins: No, I think if we're sensible here I actually described a different time period than what you described.

One of your colleagues had requested similar information, so I'm happy to speak to the ministry about it.

Ms. Catherine Fife: Okay. Thank you.

M^{me} France Gélinas: Just to piggyback on what Jeff had done, I wanted to know: When you answered his question about the PSW registry—so it's \$2.1 million annually and it will be \$2.1 million the first year. Did I get that right?

Hon. Eric Hoskins: That's certainly what I was told.

M^{me} France Gélinas: Okay. You said that the whole \$2.1 million is going to the Michener Institute, and SEIU does not have a role.

Hon. Eric Hoskins: No. Correct.

M^{me} France Gélinas: What was the transfer of money to SEIU for, then?

Hon. Eric Hoskins: There was no transfer of funds to SEIU.

M^{me} France Gélinas: Okay. All right.

Hon. Eric Hoskins: And I apologize if anything that we might have said had left you with that impression. I don't think we had referenced that. It might have been one of your colleagues, or perhaps another party.

M^{me} France Gélinas: That's why I asked: just to make it clear.

Hon. Eric Hoskins: Yes. Thanks. That's an important clarification.

M^{me} France Gélinas: Okay. I appreciate the clarification.

The data that you just quoted to MPP Fife was data, you said, from April to September for Grand River, and you seemed to be looking at a paper in front of you. Can we have a photocopy of this paper to go around?

Hon. Eric Hoskins: I'm certainly happy to talk to the ministry about it.

M^{me} France Gélinas: Happy to talk to the ministry about it and giving it to the Clerk to photocopy are two different—

Hon. Eric Hoskins: I appreciate the request, and I will look into it.

M^{me} France Gélinas: Why are you not able to say yes to sharing information that you keep quoting to us? It seems like a little bit of goodwill here. You have the paper in front of you. We have a Clerk that's more than willing to make photocopies so we can all look at the same data and not have this tension in this room.

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Mr. John Fraser: I don't feel tension.

Hon. Eric Hoskins: Yes, I don't feel the tension, but I certainly am committing to look into it for you.

M^{me} France Gélinas: All right.

A completely different topic: The multiple sclerosis association of Ontario is fully aware of who has access to physiotherapy and who does not. A large number of their members could benefit from physiotherapy, but are not able to pay for such a service. Is there any money put aside anywhere for them to gain access to rehab, if they are not admitted into a rehab centre but living in the community, but still needing rehab services?

Dr. Bob Bell: Quite a few patients with multiple sclerosis, as you know, are cared for with home care. Home care services do provide physiotherapy and occupational therapy, as appropriate, for those patients.

M^{me} France Gélinas: As I said, they are fully aware of how to gain access. It's for people who do not qualify for home care, have not been recently discharged from a hospital or are not over the age of 65. For everybody else, is there hope that access to physio could be made available without fees, or no?

Dr. Bob Bell: As I understand it, our physiotherapy clinics do have access to funding for a certain proportion of patients on an annual basis with eligibility and service maximums. Some of these patients could be patients with multiple sclerosis.

If I can expand on that—I just got a note here—in 264 community physiotherapy clinics in 150 communities across Ontario, across all 14 LHINs, over 130,000 patients received physiotherapy, with over 1.1 million service visits in the community; 75% of the patients served through community physiotherapy clinics were seniors. As you know, we get information regarding outcome of treatment, and 90% of patients did show significant improvement on standardized testing following their physiotherapy treatments.

I don't have data specifically on patients with multiple sclerosis. The expectation is that some of those patients would have had MS.

Hon. Eric Hoskins: If you'll allow me to add as well, we fund MS clinics across the province. There are currently sites in Hamilton, Kingston, Ottawa, Thunder Bay and Toronto. They serve approximately 20,000 patients with MS. These are comprehensive, interdisciplinary teams in health care that focus on the specific needs of patients. These models, these MS clinics, which are now spreading across Canada because of their effectiveness and impact—according to the MS Society itself, they describe them as the best practice for the treatment and support of MS patients.

M^{me} France Gélinas: Any intention of ever serving the northeast of the province with such a clinic?

Hon. Eric Hoskins: That's a very good and legitimate question in terms of our mutual determination to ensure that all Ontarians have access, including reasonable geographic access, to services.

M^{me} France Gélinas: How much would it cost to provide access in the northeast?

Hon. Eric Hoskins: I'm not familiar with what that might cost.

Interjection.

M^{me} France Gélinas: Sorry, I couldn't hear you.

Dr. Bob Bell: I don't think we'd have that estimate immediately available.

Hon. Eric Hoskins: Yes. Regrettably, I don't have the investments for the existing sites. That would probably give us a good sense of what it might cost in northeast Ontario.

M^{me} France Gélinas: Okay.

Jumping around a little bit, there are a whole lot more questions about Lyme disease. One of the big ones is that we don't seem to have the capability to enable collection of data on Lyme disease. Does your ministry collect data on Lyme, and if it does, who does it and what does it look like?

Dr. Bob Bell: Do you want me to start?

Hon. Eric Hoskins: Go ahead.

Dr. Bob Bell: In July 2016, as you know, there was the release of the 10-step action plan related to Lyme disease.

M^{me} France Gélinas: I'm fully aware.

Dr. Bob Bell: Certainly, the information regarding monitoring the spread of Lyme disease, monitoring the spread through the infestation of infected black-legged ticks, is gathered by Public Health. The information that I have related to confirmed cases of Lyme disease is generated by Public Health Ontario, recorded in iPHIS, which is the public health information system.

I'll just read you the last few years' data. In 2013 there were 179 confirmed cases; in 2014, 158; in 2015, 377; 2016, 322; and this year, the estimate, current as of October 10, shows 591 cases. As well, in each year probable cases could be added to that. As you know, there is an increasing number of cases being confirmed by Public Health Ontario on an annual basis.

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have a minute and a half.

Hon. Eric Hoskins: And Lyme is a reportable disease through Public Health Ontario. Public Health Ontario aggregates those figures on an annual basis.

M^{me} France Gélinas: So only the confirmed cases are reported to the health unit?

Dr. Bob Bell: Also probable cases.

M^{me} France Gélinas: And probable cases also. All right. Of the numbers that you have given me, are you able to give the distribution of those?

Dr. Bob Bell: We can look into that.

Hon. Eric Hoskins: We don't have them before us but we're happy to look into that. Can I say this? I'm working very closely with your colleague MPP Mantha. If you speak to him, this is a good example of how we're co-operating on a beyond-emerging disease, but one which is incredibly important for Ontarians. We're just now creating a task force comprised of experts, clinicians and, importantly, advocates and people with lived experience that will give us advice and oversee our policy

decisions—everything from treatment to prevention to education to research.

M^{me} France Gélinas: Is there any chance, as we go through those, that we will see more patient engagement on that? There is a really huge, pent-up demand for patients to be engaged at different levels and they don't seem to find their voices within the existing system.

Hon. Eric Hoskins: More than 30% of the individuals on the task force are people with lived experience.

The Chair (Ms. Cheri DiNovo): And that's time. Thank you both. We now move to the government side: Mr. Fraser.

Mr. John Fraser: How are you doing? I wanted to go back to the Patients First Act. We passed it last year and that act gave a legislative framework for the transfer of responsibilities from the CCAC home and community care to the LHINs. From my local experience, I know that in the last five months the wait-list for home care has dropped by about three quarters in the Champlain region, and the median wait time is about a week. There was, of course, some investment that led to that, as well.

I think my question is really more related to—that's my local experience. I know that this transition from the CCAC to the LHIN, the responsibility for home and community care, was a big change, so there may be different experiences in different areas. If you could explain that transition and the new responsibilities and how that transition has gone across the province; your particular views on that would be great.

Hon. Eric Hoskins: Thank you. I'm going to be inviting Tim Hadwen, who is the ADM responsible, to come up and speak in more detail. Thank you, Tim, just as an introduction.

It's great to hear about your local experience; you're not alone. The wait-list for home care in Champlain has gone from approximately 5,000 down to approximately 1,000.

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What was extremely important to us when we made the decision in Patients First to bring the CCACs under the LHINs was not to just have a governance or structural change, but to have a meaningful change that would result in better quality of care for patients, including home care clients and others in the community. I have to say that the leadership of our LHINs and those across the health care system—they've really stepped up to that aspect of the challenge, and we're seeing the results.

Also, the savings that we accrued as a result of that transition, we've reinvested back directly into front-line services, which is important. I think that's an expectation of Ontarians, and it was certainly our expectation as a ministry and mine as minister to ensure that those savings were reinvested in that fashion.

The Patients First Act does a number of different things, as you can imagine even just from the title alone, but one of the most important aspects was to further that process of further integrating our health care system. We've developed over many decades a health care

system which, in many cases, is unnecessarily siloed; I think we can all think of examples where that happens.

We felt that one important step as we were changing the activities or the functions, if you will, that were historically undertaken by the CCACs—which was the work, again, of Gail Donner and her task force on home community care—was that, as we not only focused on the functions, we also created a structure and a governance that we felt was more amenable to that integration of services and a better coordination of services, because people often don't simply touch one part of the health care system; they often intersect with a number of parts.

Bringing the CCACs under the governance and administration of the LHINs allows us to coordinate those activities better with long-term care, our hospitals, community activities and agencies, and other work that's being undertaken. Similarly, creating a formal, stronger relationship with public health and our LHINs, recognizing that our public health providers are among the best experts in this country—many of them, in the world—on the social determinants of health, population health and prevention, is to benefit from their vision, expertise and experience right across our health care system.

I'm a public health physician myself. I believe our public health doctors, nurses and other professionals within the public health system can have great positive influence throughout the health care system, because of their ability to understand, focus on and develop policies, procedures and supports that focus, again, on not just the narrow aspect of health care, but the social determinants of health, as well as population health and prevention.

It speaks to what our goal is, really, which is not about the structure; it's about the outcomes, to bring our health care system closer together so that everybody has a better understanding of what their neighbour in the health system is doing, and so that we create those opportunities where they can work together and build it in an integrated fashion—again, like I so often say, flipping the telescope or the lens around, so that we're not looking at our health care system as silos or a set of programs and services. We flip it around and imagine it from the perspective of the patient. The earlier comment about patient involvement in decision-making is so important to this same issue.

If we think of what will result in the best patient outcomes, the best patient experience, a more coordinated experience, a more seamless experience, when we ask those questions, it inevitably, I would say, leads us to that place which is described in the Patients First Act, where we require our LHINs to have patient and family advisory councils, where we require every hospital to have patient and family advisory councils; the involvement of patients, advocates, clients and caregivers at every touch point of our health care system and part of the decision-making process.

In a sense, there are a number of things that together comprise the Patients First Act. I'm really proud, I think, of the overall vision. It's interesting to know, even if we step backwards by another year or year and a half and

think of when we first released as a ministry the Patients First action plan—to go from that vision and that concept—it's not like "Patients First" is some magical slogan. It wasn't the first time that it was used, but it has had the effect of so many individuals and entities in the health care system changing their approach to the delivery of health care, so that, at the front end of their decision-making processes or deliberations, they imagine what difference this will make in the lives of the patients or the clients or the caregivers or the family members and others.

It's almost like a philosophical shift in how we deliver health care, and it's really gratifying to me, three and half years after becoming health minister, to now see that same language—not only just the language being reflected back at me thousands of times from individuals in the health care system, but more importantly how that Patients First approach is being reflected in the work that's being done and the attitude and the approach that's being taken in our health care system.

To take it back to your question about what we've done, I'm confident that the changes that we're made in the delivery of home and community care—by bringing that into the LHINs, as you've demonstrated in your comments about the Champlain LHIN and the quite dramatic reduction in the wait times, those are the kinds of outcomes that we always envisioned as we were drafting the act itself and imagining what a different structure in governance might look like. It's all about the patient and the client. You need the right forum to get the right function to get the right outcomes, so that was the thinking behind the development of the act in the first place.

Chair, have we got ample time for Tim to make some comments?

The Chair (Ms. Cheri DiNovo): Eleven and a half minutes.

Mr. Tim Hadwen: Good afternoon. I'm Tim Hadwen, the assistant deputy minister in the health system accountability, performance and French-language services division of the ministry.

Thank you for the opportunity to speak with you and provide an overview of the LHINs' expanded role and the new responsibilities in our health care system. I'd also like to provide an update on the transitions of the community care access centres to the local health integration networks that occurred this past May and June.

Starting with a further overview of the new LHIN responsibilities, the Patients First action plan for health care focuses on five overarching goals: (1) effective integration of services and greater equity; (2) timely access to and better integration of primary care; (3) stronger links to population and public health; (4) more consistent, accessible and culturally adapted home and community care; and (5) inclusion of indigenous voices in health care planning.

The passage of the Patients First Act in December 2016 represented an important step forward in achieving these goals. It does enable key structural changes to help

create a more patient-centred health care system in Ontario. The legislation is all about putting patients at the centre of a truly integrated health care system.

Specifically, the Patients First Act enabled a number of key changes to the role and mandate of Ontario's 14 local health integration networks, or LHINs. Perhaps most notably, it enabled the transfer of responsibility for the management and delivery of home and community care from the community care access centres, the CCACs, to the LHINs; however, in addition to the expansion of their role with respect to home and community care, the Patients First Act made a number of other key changes to the LHINs' mandate. It made changes to their overall governance.

Firstly, it amended the LHIN objects in the Local Health System Integration Act to enable the LHINs' expanded mandate, including providing the authority to deliver the home care services previously provided by CCACs. It also specified that the LHINs must work to "promote health equity, including equitable health outcomes, to reduce or eliminate health disparities and inequities, to recognize the impact of social determinants of health and to respect the diversity of communities and the requirements of the French Language Services Act in the planning, design, delivery and evaluation of services." It also added participation in the development and implementation of health promotion strategies as a legislated object of each LHIN.

Secondly, the act required LHINs to establish sub-regions as the focal point for local planning and performance.

Thirdly, it expanded LHIN board membership from nine to 12 members to respect and better support the LHINs' expanded mandate.

The act also enabled the establishment of Health Shared Services Ontario to provide shared service support to the LHINs for crucial items like IT and payroll.

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The last one I'd like to mention is that it required each LHIN to have at least one patient and family advisory council to support patient and family engagement in local health system planning.

The act also forwards integrated care by having the LHINs take on an expanded role with respect to primary care planning, including establishing a LHIN object of identifying and planning for the health service needs of the local health system, including needs regarding physician resources; and allowing LHINs to fund and have accountability relationships with additional health service providers, including family health teams, aboriginal health access centres and nurse-practitioner-led clinics. The act supports stronger linkages with public health and joint health services planning by establishing a formal relationship between LHINs and local boards of health.

Perhaps lastly to mention, it also gave LHINs enhanced oversight and accountability measures, including the ability to issue directives and to investigate and supervise health service providers—with some exceptions for hospitals and long-term care—to support their mandate as local leaders of the health care system.

Taken together, all of these changes enable the LHINs to take on an enhanced leadership role within their local communities, to drive system integration and improve patient experience. They can support more effective service integration and improved health equity. They can support improved access to primary care and more seamless links between primary care and other services. They can support more consistent and accessible home and community care and enable stronger links between population and public health and other health services.

I'd like to spend a little bit of time to speak to you about the implementation of the Patients First Act, specifically the transition of home and community care to the LHINs. The Patients First Act made legislative amendments to enable the transfer of all of the assets, liabilities, rights, obligations and employees of the CCACs to the LHINs through a transfer order signed by the minister. The minister signed 14 transfer orders ordering the transfer of the 14 CCACs into their respective LHINs in a staged manner over the course of eight weeks in May and June 2017.

As a result of months of careful collaborative planning involving the ministry, LHINs, CCACs, Health Shared Services Ontario and other key system partners, the transitions occurred smoothly, with patient care and continuity of key business functions of the CCACs and the LHINs maintained throughout. I'm pleased to have the opportunity to speak to you briefly about how these transitions were able to occur so smoothly.

From the time of the Patients First Act first being tabled in the Legislature, the ministry began the process of implementation planning for the change that the legislation enabled—namely, the transfer of the employees and functions of the CCACs into the LHINs, which entailed not only the transfer of the employment of approximately 7,000 CCAC staff working to provide high-quality care to the Ontarians receiving home care but also support for the LHINs in taking on that responsibility.

To ensure that support, the ministry established 16 transition work streams, each focused on a specific aspect of the transition, ranging from management to capacity-building to readiness to public health, primary care and home care. This was an exemplification of the truly collaborative nature of the project, with each work stream having a ministry and LHIN lead.

Each was tasked with delivering on clear objectives and identifying the right membership and expertise to achieve those objectives. Each included members from across multiple branches and divisions within the ministry, LHINs, CCACs and other organizations. In total, there were over 150 people dedicating their time and effort to ensuring a smooth transition of CCACs to LHINs and, in the process of doing so, harnessing the collective collaborative capacity to foster change in the health care system.

Communication with a wide range of system stakeholders was prioritized and was crucial to the success of the transitions. In addition to the system partners with

direct involvement in the work streams, a broader network of health system stakeholders was engaged as key informants on many of the work streams. The ministry also implemented a regular weekly reach-out with a mailing list of approximately 3,000 recipients to provide regular updates on implementation planning throughout the process.

Through those strong working relationships built, the team members were able to plan for transition requirements, mitigate potential risks and engage stakeholders fully in the LHIN renewal endeavour.

The project's structure also included an equity lens with specific work streams for patient and family engagement, indigenous engagement and French-language services, which ensured that the experience and knowledge of these constituencies was included in renewal planning and was integral to the establishment of the newly constituted LHINs.

The close collaboration between the ministry, the LHINs, the CCACs and health system partners was also demonstrated in overall project governance management established for the project, which was overseen by a steering committee comprised of all of the LHIN CEOs and members of the ministry's senior executive team.

Readiness assessment and capacity-building site visits were completed with each of the LHINs by Deloitte, which was procured as a third-party consultant. Deloitte worked closely with all 14 LHINs to ensure they were prepared to assume the functions and responsibilities of the CCACs on transition day. There was a detailed readiness checklist which guided the LHINs through must-have activities to be completed in the days leading up to transition. The primary objective throughout the transition was to ensure continuity of care.

The Chair (Ms. Cheri DiNovo): Mr. Fraser, you have two minutes.

Mr. Tim Hadwen: We can advise that the effort to ensure continuity of care was a successful one. The LHINs engaged in monitoring closely contacts related to transition. Only a handful of concerns were raised, and those were addressed.

There are a couple of other aspects of the transition that I'd like to spend a minute on. One was the successful establishment of Health Shared Services Ontario, the agency providing key shared service support to the 14 LHINs in their newly expanded mandate, created through a merger of the three pre-existing entities that previously provided key supports to the CCACs and the LHINs, including the Ontario Association of Community Care Access Centres, and ensuring the strong continuity of the management of the client health and related information system, or CHRIS, which is a key patient data platform that supports the delivery of home and community care by the CCACs and now the LHINs.

Another aspect to highlight is the establishment of a new sub-regional planning focus. The Patients First Act enables improved local health planning through the establishment of LHIN sub-regions. Each LHIN has finalized sub-regional maps and is engaged in the process

of sub-regional planning. Sub-regions were created as planning zones to support regional health system planners to implement solutions that fully address the wide range of patient needs across diverse communities.

Because each LHIN is responsible for planning health care services for large and varied populations ranging as high as almost two million people, using sub-regional LHINs helps LHINs to focus their planning activities on a smaller population to ensure that health services are designed to meet the needs of the specific population they are there to serve.

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up. We now move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Minister, back to where we left off. This agency which will be hiring PSWs—how are the PSWs going to be compensated? On a case-by-case basis or are they going to be salaried or are they—

Dr. Bob Bell: You know, over the past couple of years, following the publication of Dr. Donner's report and the adoption of a 10-point plan for home care, we've worked toward a standard rate for personal support workers to be provided as well as increasing by \$4.50 an hour over three years the amount compensated to PSWs. That standard rate will be paid for the work of the PSWs in this self-directed care model, a similar rate that is provided to other PSW services.

Mr. Jeff Yurek: You mentioned that there may be regional agencies of this agency. Can you elaborate on that, considering that LHINs are regional bodies?

Dr. Bob Bell: As far as I'm aware—and I'll ask Mr. Dicerni to come up to make sure that I'm remembering correctly—we're not planning regional agencies. We may, if this is as successful as expected, think about regional offices as this program grows, but that is not the case at present.

Mr. Jeff Yurek: How are you going to create this roster and what size—are you going to take names of PSWs from current agencies or—how are we going to create this roster?

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Dr. Bob Bell: The expectation is that these PSWs would certainly all be sourced from individuals who are registered on the PSW registry as a starting point. We think that some of the PSWs working in this field are looking for this kind of a consistent client model, where clients who require significant support at home—over 14 hours a week, as mentioned—would develop relationships with their care providers that would be perhaps less transient, more intimate in the relationship that could develop between care providers over periods of time. That's the kind of PSW we think will be looking for this kind of work.

Mr. Jeff Yurek: And the current home care providers couldn't provide this service. Is that basically what you're saying?

Hon. Eric Hoskins: Not under this model; that's correct.

Mr. Jeff Yurek: In general, you're creating this model because there's a gap in the system, where home

care providers can't offer what you're trying to create? Have you spoken to them about this gap?

Hon. Eric Hoskins: Based on the recommendations of Gail Donner and her task force to offer—and in fact, there are two models that will be offered up. There is direct funding that will be offered up to a small cohort of clients as well: those who do have the confidence and are comfortable and want to purchase home care services directly themselves. That opportunity will be expanded. This specific entity, which is memorable and easy to recall—self-directed personal support services Ontario—will allow for PSWs to apply to be part of the roster, as was referenced by the deputy. The advantage of having the PSW registry simultaneously will be to give additional confidence. But we felt, looking at different models—particularly because, in the first instance, as we test this, we're looking at a relatively small cohort of clients, a subset of the complex ones that the deputy referenced, with greater than 14 hours of care required each week. We feel that this is the best model, in a controlled fashion, to test its viability and ensure that all of the necessary accountabilities are in place to protect both the client and the provider of care themselves.

Mr. Jeff Yurek: Maybe I've asked this already, but are they technically, then, an employee of this entity?

Hon. Eric Hoskins: Yes.

Mr. Jeff Yurek: So they just give their name, and they're employees. Technically, are they an employee of this agency and then another home care agency once they're fully engaged?

Hon. Eric Hoskins: They can conceivably be both. And it's not an agency; it's a not-for-profit corporation. They would be employees of the not-for-profit corporation, but that doesn't limit them in terms of being able to be employees of other entities as well.

Mr. Jeff Yurek: Okay. As a not-for-profit corporation, are they excluded from the sunshine list that is put out every year? Do you know?

Hon. Eric Hoskins: No, I believe the sunshine list is if you receive—is it greater than \$1 million or \$10 million? What is the threshold?

Mr. Patrick Dicerni: It's \$10 million or 10% of your operating budget.

Hon. Eric Hoskins: Or 10%. It's either/or, right? So it would be in excess of 10% of their operating budget. Presumably, they would be.

Mr. Jeff Yurek: But how much were we putting toward this agency this year?

Mr. Patrick Dicerni: It's \$2.9 million.

Mr. Jeff Yurek: Is it \$2.9 million?

Mr. Patrick Dicerni: Correct.

Mr. Jeff Yurek: But it's 100% of their income, then, so they would be a part of the sunshine list.

Mr. Patrick Dicerni: Correct.

Mr. Jeff Yurek: Okay.

The Auditor General's report on CCACs noted that CCAC-employed rapid response nurses were available Monday to Friday, 9 to 5, and they found that the ministry didn't conduct an analysis to assess if service

providers could provide the same services more cost-effectively. Considering you're creating this agency, did you conduct an analysis for this non-profit corporation and assess whether the service providers can already provide this service more effectively? Did you do any analysis at all?

Dr. Bob Bell: Nursing services will not be provided by this not-for-profit corporation, Mr. Yurek. It will strictly be PSW services.

Mr. Jeff Yurek: Okay. Did you do analysis of whether the current service providers will be able to provide the same types of services that you're asking this new agency to provide, and did you do an analysis on the cost-effectiveness of the system?

Dr. Bob Bell: I don't believe we did a direct analysis of the cost-effectiveness. We're expected to pay the same rate to service provider organizations that are providing PSW services as we are to this not-for-profit corporation.

Mr. Jeff Yurek: I'm assuming the infrastructure you'll build in this agency is going to take some of that money. How are these people getting paid? How are you going to pay for the chair, the board members and the staffing that will be part of this agency? Where is that money coming from?

Mr. Patrick Dicerni: We're looking at a variety of options to support the back-office functions of this agency across the province. Final decisions on that have not yet been made, but we'd be looking to make the most efficient use of the existing assets we have in the system.

Mr. Jeff Yurek: Isn't this agency going to start in January?

Mr. Patrick Dicerni: The agency has already been incorporated, and the goal is to provide service as soon as possible.

Mr. Jeff Yurek: But you haven't figured out how you're going to pay for it, the back office.

Mr. Patrick Dicerni: We're endeavouring to make sure that we're using limited resources as effectively as possible, but relatively speaking, we will be able to move pretty quickly on establishing back-office functions, whether that's with a partner or this agency unto itself.

Mr. Jeff Yurek: How much is the board chair being paid?

Mr. Patrick Dicerni: I don't have that information at my disposal.

Mr. Jeff Yurek: Can you share it with us when you get it?

Hon. Eric Hoskins: We can certainly look at that.

I hope you appreciate that that announcement—and you're correct: It was made at the same time as Caregivers Ontario. I think there were five pieces to that.

It was only on October 5. This was a commitment to create this entity, so with respect, I hope you can also appreciate that it's still in development.

Mr. Jeff Yurek: But you appreciate that you're spending patient care dollars as of two months from now and you don't have an answer to how you're going to be funding part of this operation. As an opposition member,

this is the type of question I'm going to ask. I had hoped to get a response.

The CEO of the organization: How much will he be paid?

Dr. Bob Bell: We don't have that information. Currently, the CEO is in the process of recruitment by the board.

Mr. Jeff Yurek: You don't have one selected yet?

Dr. Bob Bell: It's in the final stages of selection and recruitment.

Mr. Jeff Yurek: How many staff do you plan to be running this organization? What's the budget for running this back-office organization, the non-patient-care aspects of this agency?

Dr. Bob Bell: I don't think we have that accurate information with us right now.

Mr. Jeff Yurek: Will you share it with us, if you can find it?

Hon. Eric Hoskins: I'm happy to look into that for you.

Mr. Jeff Yurek: Minister, you mentioned that you're creating this agency to protect employees. Are you inferring that the current PSWs—our home care providers in the system aren't protecting their employees?

Hon. Eric Hoskins: Not at all. The example I was trying to give, and I apologize if I wasn't clear—one of the reasons why we chose this model is we felt there was a significant challenge in asking home care recipients, clients, to negotiate contracts within, for example, the confines of the Employment Standards Act and other pieces of legislation; to at that level—particularly given some of the individuals that we're talking about here, those with complex conditions—provide 100% assurance that the contractual relationship adheres to the law and provides the necessary protections and safeguards for the employee. We felt that this was the model that best spoke to that.

Mr. Jeff Yurek: Who will be representing the employees of this agency?

Hon. Eric Hoskins: In what sense?

Mr. Jeff Yurek: Have you figured out who will be protecting the employees as we're moving to centralized bargaining, I guess you would say, with the home care industry with Bill 148? Are all PSWs going to be under one group?

Hon. Eric Hoskins: That hasn't been a consideration. I would imagine, similar to other entities, that it would be up to the employees themselves to determine who they wish to represent them.

Mr. Jeff Yurek: Could you share with us the total operating cost of the new expanded LHINs?

Dr. Bob Bell: The legacy cost of the LHINs was about \$90 million for 14 LHINs. That has, of course, been expanded by the transfer of the former CCAC employees. We may have that information present here. I don't think we do, but—

Mr. Jeff Yurek: Can you provide the shared service agencies, the total operating costs of the—

Dr. Bob Bell: HSSO?

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Mr. Jeff Yurek: Yes.

Dr. Bob Bell: Yes.

Mr. Jeff Yurek: I guess you've already told me the caregiver organization is \$1.3 million this year, \$2.5 million annually, and the cost of the PSW registry is \$2.1 million. So, yes, if you can just share with us the operating costs of the expanded LHINs and the shared service agency.

Dr. Bob Bell: Sorry, Mr. Yurek. We do have that information. Associate Deputy Minister Naylor can provide it to you right now.

Mr. Jeff Yurek: Great.

Ms. Nancy Naylor: In the 2017-18 estimates, we had \$85 million for the operation of LHINs. I would add, though, that that includes some of the program costs that they were asked to deliver—for example, diabetic education centres—and some of their IT priorities that they led and funded on. Our best estimate of what their actual admin costs were was about \$60 million to \$65 million. As we go forward into future estimates, it will be clearer because we've established a new cost centre for LHIN operations as well as LHIN programs delivered.

Mr. Jeff Yurek: So that's including—the CCAC is merged in there?

Ms. Nancy Naylor: That was before the CCAC merger, so as the CCACs have come in, we've asked them to define what is their administration cost and what is their patient care delivery cost.

Mr. Jeff Yurek: So you don't have that information, about the expanded LHINs, not the previous—

Hon. Eric Hoskins: I can certainly speak to the fact that with the merger we incurred significant savings, both in terms of HR and other related administrative savings. I had mentioned earlier that they were all invested into front-line care.

Mr. Jeff Yurek: I don't mean to chastise the government, but this is estimates. It's the only time we are allowed to ask for budgetary numbers, and you don't have them here.

Ms. Nancy Naylor: We do have the 2017-18, which were on the basis of pre-transition LHINs.

Mr. Jeff Yurek: We're past that. We're in—what's going on?

Ms. Nancy Naylor: We'll be tabling 2018-19, the merged numbers, but maybe I could just—

Hon. Eric Hoskins: That's why they call it estimates.

Ms. Nancy Naylor: —add these specifics to the minister's statement: When we did merge the CCACs and the LHINs, we gave them the challenge of reducing by 8%, so that did reflect a reduction of 59 management positions across the LHINs that merged the new organizational structures. Those savings were \$10.7 million, which were added to the home care budget patient services this year, so reinvested in home care.

Hon. Eric Hoskins: To add, as well, with the back end—sorry, what do they call it?

Dr. Bob Bell: The back office.

Hon. Eric Hoskins: The back office, thank you; I was thinking backroom—the back-office services. We merged three entities down into one for provision of those back-office services and incurred significant savings as a result of that, which are being reinvested into front-line care too.

Mr. Jeff Yurek: I understand you keep saying you incurred savings but you can't give me a number of how many of them—what their operating costs are—

Hon. Eric Hoskins: I think you can appreciate, we not only asked them but we withheld 8% with the merger, which we reinvested. They were asked to develop budgets which were consistent to that reduction. I hope you can appreciate that this took place over the course of May and June, quite recently. The estimates have been submitted based on the estimates for 2017-18, as appropriate, but now, with the recent merger, we are in the process of collecting what that new reality will look like.

Dr. Bob Bell: You can appreciate, these organizations started out as CCACs and then transferred their assets and their operating budgets to the LHINs. We do know exactly how much we're spending on home care, for example; the estimate is about \$2.9 billion this year. Those figures are certainly available.

Mr. Jeff Yurek: Was the review of medical malpractice insurance conducted by Justice Stephen Goudge released publicly?

Dr. Bob Bell: No.

Mr. Jeff Yurek: Is there a plan to release it?

Dr. Bob Bell: The report is still in draft. We have not yet received the final report from Justice Goudge.

Mr. Jeff Yurek: I'm getting contact with some nurse practitioners indicating the government has stopped subsidizing required professional liability protection for nurse practitioners. Is this true?

Dr. Bob Bell: No, we have not stopped providing PLP for nurse practitioners.

Mr. Jeff Yurek: Can you let me know how many clinicians to date have registered with the care coordination service to participate in MAID?

Dr. Bob Bell: We sure can. I'll reintroduce Mr. Dicerni.

Mr. Patrick Dicerni: Patrick Dicerni, ADM of the SPPD division at the Ministry of Health and Long-Term Care.

Currently we have 92 clinicians registered with our care coordination service.

Mr. Jeff Yurek: There were 181 originally from the referral list for providers, previously.

Mr. Patrick Dicerni: The clinician referral service is what you're referring to, and yes, that was a higher number.

Mr. Jeff Yurek: Do you have any understanding of why that has decreased?

Mr. Patrick Dicerni: The care coordination service is a service that allows Ontarians to directly access contact with physicians, so the willing cadre of physicians who are going to be taking calls directly from members of the public was less.

Mr. Jeff Yurek: Is this distributed evenly throughout the province, or is it in centralized locations?

Mr. Patrick Dicerni: There is representation across the province. It aligns to areas of population in the province, but it is not an even distribution.

Mr. Jeff Yurek: The Healthcare Sector Supply Chain Strategy expert panel report was released in May. However, there has been no communication with industry or the public about the report since. Can you give us an update on what's going on with that?

Dr. Bob Bell: There's a process of consultation going on with respect to the expert panel's recommendations and findings.

Maybe I can introduce Assistant Deputy Minister Justine Jackson, chief administrative officer, who is responsible for carrying out those consultations and the implementation of the report.

Ms. Justine Jackson: Justine Jackson, ADM.

We've done a lot of consultations. We've visited some places that were very impressive to the expert panel: BC in particular, Vizient down at Cleveland Clinic, and we've spoken with Alberta.

The question really is, to what extent can we centralize and how quickly, and what's the right way forward? At the end of the day, what we really want is to achieve the benefits of savings to the system and how to best do that.

As you would know, too, the report was silent on the costs of implementing the massive change, so that's something else to be considered in the future. But what we have learned over the summer with the consultation is that at this point, it's best to approach this project a little bit like the IT situation, where we re-engage the CEOs of hospitals to take more ownership of their procurements.

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up, Mr. Yurek.

We now move to the third party, Ms. Fife.

Ms. Catherine Fife: I just want to follow up on some of the questions that I had around the off-loading times for ambulances. This has been an issue that has come up at AMO, particularly for those municipalities that have been incredibly fast-growing and have cited ambulances basically just parked outside the hospital waiting for that off-load period.

In your comments to me in response to the St. Mary's incident that I mentioned around the hallway nurse—I don't think I was clear. She wasn't actually in the emergency room; she was in the hallways behind the emergency room, all of the areas that surround the emergency room. There were beds in hallways.

You had mentioned—or the minister, or Dr. Bell—that the average provincial ambulance off-load time is around 34 minutes. Do you have the documentation that I can cite in regard to that off-load?

Hon. Eric Hoskins: Thank you for the question.

I think I referenced that at St. Mary's itself, their average off-load time is 34 minutes. I believe we have 50 hospitals participating in the dedicated off-load nurses program across the province, so we have seen across the

board a reasonably significant decrease already in off-load times as a result of that.

But there's no question that we continue to have work to do. That's part of the reason, for example, why we have proposed legislation that will enable our EMS workers or paramedics, using their best clinical judgment, to choose other opportunities for off-loading other than specifically and solely a hospital emergency department. We expect that will result in even more streamlined emergency experiences, as well as the opportunity for paramedics and EMS workers to deliver individuals to the point of care which is best for them.

1730

M^{me} France Gélinas: Coming back to the number, when you quoted the 34 minutes, you said the 34 minutes was the provincial average and that St. Mary's was below this. But now you have come back and said, no, St. Mary's was 34; it was below the provincial average. What is the provincial average?

Hon. Eric Hoskins: The provincial average is 42 minutes.

M^{me} France Gélinas: The provincial average is 42, and St. Mary's is 34. This, I take it, is at the benchmark of 90th—

Hon. Eric Hoskins: Yes. Also, if I can clarify, because I have before me, as signed by me, that the Ministry of Health and Long-Term Care provided the regional municipality of Waterloo with \$516,173 in funding for this year to support dedicated nurses to receive ambulance patients, so that in fact was ministry money that you referred to earlier.

M^{me} France Gélinas: Of the average of 42 minutes, do we have a benchmark? The average is 42. Is 42 also the benchmark?

Hon. Eric Hoskins: I don't have such a benchmark before me. I'm not sure if one of the officials might.

M^{me} France Gélinas: Deputy, would you know?

Dr. Bob Bell: We measure this as part the performance that hospitals are measured on for the pay-for-performance emergency department funding, which is about \$100 million. We don't have a benchmark but we do expect to see each hospital improving. If we look at the 90th percentile length of stay for emergency departments and we look at the data from July 2017 which was just placed in front of me, we measure overall ED length of stay for all patients: complex patients who are going to be discharged, complex admitted patients, complex non-admitted high-acuity patients, non-admitted low-acuity patients, time to physician initial assessment and time to in-patient bed. We rank each hospital on all these features in terms of determining their quality improvement and qualification for the pay-for-performance funding.

M^{me} France Gélinas: I used to be on public accounts. The AG used a 30-minute benchmark for 90% of the people, as a benchmark for off-load for the province. We don't use that anymore?

Dr. Bob Bell: I'm not aware of that. I can check and see if that's a figure that we're looking at. What we tend

to do is we tend to look for each hospital, each emergency department, to participate in the process of ongoing quality improvement and demonstrate improvement, as opposed to setting benchmarks for each of these figures.

M^{me} France Gélinas: Okay, but we do have the average for every hospital?

Dr. Bob Bell: We do.

M^{me} France Gélinas: We do? Okay. And you wouldn't share that with me and save me five bucks; I'm going to have to go through FOI to get that?

Dr. Bob Bell: For each hospital?

M^{me} France Gélinas: Yes.

Hon. Eric Hoskins: We can certainly look into that for you.

M^{me} France Gélinas: Okay. I'm interested in finding that out. Thank you.

I'm going to continue on a question that Jeff had that has to do with the professional liability protections for nurse practitioners. Nurse practitioners were covered under RNAO like everybody else. The ministry transferred money to RNAO, and RNAO transferred money to the CNPS, and this is how every nurse got their personal liability protection. We all know that NPAO, the nurse practitioners, are no longer part of RNAO. How does their personal liability protection get paid for now and how are they identified in all that?

Hon. Eric Hoskins: We have a contractual relationship, as you mentioned, with RNAO which enables them to offer liability insurance to nurse practitioners across the province, and then, of course, many employers provide, independent of what I just referenced, liability protection for their nurse practitioner employees as well.

M^{me} France Gélinas: So what happens once NPAO is no longer a member of RNAO? The nurse practitioners are no longer members of RNAO. How do they get their professional liability protection then?

Hon. Eric Hoskins: They can still be members of RNAO, and we have never had a contractual relationship with NPAO for the provision of liability insurance for nurse practitioners.

M^{me} France Gélinas: What do we do with the 2,200 NPs who are members of NPAO and not members of RNAO who work in our community, who need professional liability protection?

Hon. Eric Hoskins: As I mentioned, many employers provide that protection as well, but we're in consultations with our nurse practitioners and the associations that represent them to consider, if necessary, any further developments or refinements.

M^{me} France Gélinas: Could you share with the committee how much money the government spends on personal liability protections for nurse practitioners? Because first of all, I tried to follow the money, and it's really hard to do that.

I see a little paper coming through; that's always a good sign.

Dr. Bob Bell: Yes, \$90,000 is provided to RNAO to provide PLP for nurses.

M^{me} France Gélinas: You don't make any difference as to—

Dr. Bob Bell: Sorry, to nurse practitioners.

M^{me} France Gélinas: To nurse practitioners?

Dr. Bob Bell: Yes.

M^{me} France Gélinas: Has this amount gone down significantly since—the amount has stayed the same?

Dr. Bob Bell: We provide the same amount.

M^{me} France Gélinas: Okay. Is it just me who thinks there could be a problem there? Most nurse practitioners are no longer members of RNAO, and yet the ministry still pays RNAO to insure nurse practitioners that are no longer with them.

Hon. Eric Hoskins: NPAO had been providing liability insurance for its members, and it decided on its own to no longer provide that protection.

M^{me} France Gélinas: Because they were paying for it themselves, and the ministry is paying for their members through an association that no longer represents them.

Hon. Eric Hoskins: Well, they have the opportunity to receive liability insurance through RNAO.

M^{me} France Gélinas: Okay.

Hon. Eric Hoskins: The sole contractual relationship we have had, certainly since I've been minister, for the provision of liability insurance for nurse practitioners has been through one entity, through RNAO. That opportunity for protection is available to every nurse practitioner in the province, notwithstanding the fact that many employers provide liability protection on their own.

M^{me} France Gélinas: But it's only available to them if they join RNAO.

Hon. Eric Hoskins: Effectively, but the liability protection is available to all nurse practitioners through RNAO, which has always been the case, certainly, at least, in recent years.

M^{me} France Gélinas: Okay, I'll frame this differently. Would you consider, given that—I mean, nurse practitioners have spoken quite loudly that they wanted to disassociate from RNAO for their own reasons. Most nurse practitioners are no longer members of RNAO; 2,200 of them are members of NPAO, which means that the support that you are giving them is no longer accessible to them.

Hon. Eric Hoskins: Well, it remains accessible. That being said, we are talking with nurse practitioners and the entities that represent them to ensure that they have the confidence they need to be adequately protected, whether that's by employers or through other means.

M^{me} France Gélinas: Is there a chance that this \$90,000 that's going to RNAO to insure nurse practitioners could go to NPAO to insure nurse practitioners within their association?

Hon. Eric Hoskins: We currently do not have plans for that.

M^{me} France Gélinas: Why not?

Hon. Eric Hoskins: Well, as I mentioned, the sole mechanism for government-funded liability protection for nurse practitioners, at least for the past four years—I can't speak to before I was minister—has been the provision of that protection via RNAO, and that opportunity

continues to exist for all NPs in the province. For those that perhaps aren't protected by their employers, the opportunity to receive liability protection through RNAO exists to this day.

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M^{me} France Gélinas: So they have to pay membership into RNAO in order to gain support from the government to pay for their professional liability protection?

Hon. Eric Hoskins: I'm not sure of the particulars. That would be a question, I think, for RNAO.

Dr. Bob Bell: In fairness, I think part of the difficulty is understanding the kind of coverage that many nurse practitioners have through their employment status. That's something the ministry is investigating now, as to what sort of gap might exist in PLP for nurse practitioners. It is complex because, quite frequently, people are unaware of it. We're trying to sort that out currently.

Hon. Eric Hoskins: Just to reiterate what the deputy is saying: That is the basis or the reason why we've been having, for some time, those discussions. Really, the issue here is to ensure that nurse practitioners have confidence that they're adequately protected for liability purposes.

M^{me} France Gélinas: And through RNAO, do you pay 100% or 85%?

Dr. Bob Bell: I believe we pay 100%.

Hon. Eric Hoskins: Yes, we do.

M^{me} France Gélinas: Okay. For everybody else—for midwives, you pay 100%. It's only physicians that you don't pay 100%; you pay 85%?

Dr. Bob Bell: Correct.

Hon. Eric Hoskins: Yes, correct.

M^{me} France Gélinas: So everybody else is covered at 100% if they go through their association. Okay.

A change in topic: We're going to talk about public health. There are a number of municipalities, including mine, that have written to you about the changes to public health. I'm reading a letter from Brian Bigger, who is the mayor of the city of Sudbury, that was addressed to you, Minister:

“Our concerns include:

“—loss of a local voice in directing public health programs since social determinants of public health are often influenced by policy decisions that rest with municipal decision-makers;

“—reduction of elected municipal representatives sitting on the board of health;

“—LHINs are recognizing the need to be more local through sub-LHINs, while the proposed changes” to the public health unit “would make public health delivery more regional than it already is;

“—potential to cause significant service disruption to public health initiatives while implementing the recommendations along with increased financial costs associated with the recommendations;

“—exclusion of elected officials to act as chair or vice-chair of the board.”

It goes on; it's a two-page letter.

Where are we at with the changes to public health?

Hon. Eric Hoskins: First of all, we have not proposed any changes to our public health system. We have not released any policy statements or policy proposals with regard to any changes. I think it's important to clarify that.

What I have done is, I've released the recommendations of the public health expert panel report, which was a panel that was created by myself in January of this year, an expert panel on public health to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system. These were individuals who were chosen for their knowledge, experience and perspectives.

In June, they presented their report. Subsequently, the recommendations have been made available. In fact, a day before or a day after those were made available, I briefed AMO through the MOU table on the contents of their report. But again, there have been no policy recommendations or changes proposed by this government. Simply, we've released the recommendations of an expert panel.

M^{me} France Gélinas: When you asked for the opinion of the expert panel, why did you do that exercise if you intend to do—you seem to be saying that you'll do nothing with this. Why waste the time of those good experts if you have no intention of doing anything?

Hon. Eric Hoskins: On the contrary, we have invited and, I would say, received a robust conversation and consultation on the recommendations that are being promulgated by the expert panel. I can't remember the precise date; I think it was some time in late August when those recommendations were made public, and we circulated them broadly and invited responses. As I mentioned, the first interaction that I had was with AMO itself, but certainly public health units have been very engaged, and that's precisely the kind of feedback that we have invited and we welcome.

M^{me} France Gélinas: How long is the consultation period, and what is the next step?

Hon. Eric Hoskins: I believe the consultation period ended today, or ends today.

M^{me} France Gélinas: It ended today. So what is the next step?

Hon. Eric Hoskins: I would think you can appreciate, given that it still has a number of hours left before it concludes—but we have also received a considerable number of written submissions and the ministry has had meetings as well with invited stakeholders to obtain their reflections.

M^{me} France Gélinas: So you will look at the report, you will look at the feedback you're getting from the different municipalities, from AMO, from people who wrote in, from the Ontario Public Health Association, from the Chief Medical Officer of Health, from all of those, and then what?

Hon. Eric Hoskins: I understand at some point we're going to have to declare ourselves one way or the other, but I find it humorous that we're often criticized for not consulting enough or just asking, through the consultation process, to rubber-stamp, when in fact this is a nat-

ural and elegant case of how we had independent experts provide advice, and then we released that advice to our stakeholders, and now we're just about to conclude, as I referenced, that consultation period. We'll take the time to review the feedback that we've received and then act accordingly.

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have just over two minutes.

M^{me} France Gélinas: Who in your ministry is doing that work?

Dr. Bob Bell: The expert panel was co-chaired by our Chief Medical Officer of Health, Dr. David Williams. The consultation process is being led by Dr. Williams, who has been around the province discussing the recommendations, as well as ADM Roselle Martino, who was speaking earlier.

M^{me} France Gélinas: They will be the ones who will continue to—last year, when I asked you about public health funding, you made it clear that the envelope for public health was not going up and that a number of public health units—I forgot the exact number; I think 29—had been red-circled. A few of them that were experiencing high growth were going to receive a bit of funding. Is this still the same for this year?

Hon. Eric Hoskins: The approach is the same. It's important to recognize that last year those funding decisions in terms of distribution of funding among public health units were predicated on a new funding formula that was, quite frankly, a multi-year process involving those in the public health system themselves. That led to a formula which has dramatically improved, because it does reflect not only population needs in a particular jurisdiction but also important issues such as population growth. The result of that formula was that additional funding would be provided to those specific public health units that perhaps deserve to have a greater level of funding because of their unique characteristics.

M^{me} France Gélinas: How many of them are still red-circled to not see a budget increase?

Dr. Bob Bell: Just to answer your former question, Madame Gélinas, if I may, the other thing that's happening, as you know, is that the provincial allocation in public health units is to support the provincial standards of public health. One of the things that we have been aggressively engaged in over the last year is re-evaluating those provincial standards. Some of them have been changed and decreased, so the amount of work that's expected for some of those standards at the local public health units has changed as of—

Ms. Roselle Martino: It will come into effect January 1.

Dr. Bob Bell: —January 1, so in this fiscal year.

The Chair (Ms. Cheri DiNovo): I'm afraid the time is up now. Thank you.

We now move to the government side: Mr. Fraser.

Interjections.

Hon. Eric Hoskins: Sorry.

Mr. John Fraser: That's okay. No, take your time. My question is going to be on the dementia strategy, so you can prepare for that.

Some 175,000 Ontarians currently suffer from dementia, and that number is projected to continue to rise, which is going to put a lot of pressure on all of our health care system, but really and specifically on home and community care and long-term care.

There are 175,000 people who suffer from dementia, but their families, their caregivers and their friends suffer as well in different ways. I have some personal experience with that. My father suffered from dementia in the last three years of his life, and I have some family members who are currently suffering from dementia. The effects are very clear on a family inside a support group—the emotional effects that it has on people dealing with a loved one who is really cognitively impaired, sometimes in different ways.

1750

It's unusual, the way that it expresses itself. You'll get someone you can have a coherent conversation with but they can't tie their shoes or execute functions. That can be really hard on a family member. Sometimes you have family members, especially aged people who are living with support but continuing to live together. Even though that other individual who has fuller function is getting health care support, there's still the stress and pressure on them of that constantly being together.

I wanted to relate those things from personal experiences because I think they're kind of critical in talking about these things—that we recognize that there are effects that go across our community, across our society and across our families.

I know that in last year's budget we set aside \$100 million over three years for a dementia strategy. Can you speak to how that is moving forward in terms of that investment and give us some idea of how it's rolling out? What are the key elements that you have in that strategy?

Hon. Eric Hoskins: Thank you for that question. It's extremely important because we all know that we live in a world where the demographics are shifting and we're seeing more of our population in the older demographic, the senior population.

It's important to recognize, as well, that dementia impacts more than just seniors. It can also, tragically, occur at a much earlier age. I would suspect that probably everyone or nearly everyone in this room has a personal experience, either a family member or a close friend or a colleague or a neighbour who has suffered with the tremendous challenge that comes with, say, Alzheimer's disease, which is a form of dementia, or other forms of dementia as well. That's why it's so critically important.

When you look at the numbers, the fact that we're going to see roughly, it's estimated, a 50% increase in the number of Ontarians with dementia just in the next five years, is extraordinary. We need to have confidence in the health care system, and more than just the health care system—a caring society that is able to provide the necessary supports given that we're seeing that fairly dramatic escalation. It was extremely important to this government to develop, elaborate and begin to implement, on top of our previous investments, investments

that speak to a well-thought-out and articulated dementia strategy. So that's what we've done.

In the spring budget, as you've referenced, we announced an additional \$100 million over a three-year period which will go specifically to that strategy and realizing its goals.

How many minutes do we have, Chair, on this, roughly?

The Chair (Ms. Cheri DiNovo): About six and a half.

Hon. Eric Hoskins: Six and a half; okay. I'm not going to steal all the thunder; I'm going to give some to Patrick Dicerni, who is tremendously able to respond effectively to this question.

Mr. Patrick Dicerni: Patrick Dicerni, assistant deputy minister in the strategic policy and planning division at the Ministry of Health.

Thank you very much for the question. It's a pleasure that I get to talk about the formulation of the strategy. I'll take a few steps back from the minister's comments and describe to the committee how we came about arriving at the strategy, what our development was and what some of the intended outcomes of the strategy are.

Through our estimations, there are currently about 194,000 people who have received a diagnosis of dementia. This number is expected to grow, as the minister mentioned, to 206,000 by 2020, and it's anticipated to exceed 300,000 by 2038.

While dementia is most common among seniors, it's also important to note that one in about every 1,000 people under the age of 65 can develop early-onset dementia.

As you can well imagine, the economic and social impacts of dementia are substantial in our system. Cumulatively over the period of 2008 to 2038, as anticipated, dementia will cost Ontario close to \$325 billion in direct health care costs, indirect costs and opportunity costs to care partners. There is also considerable financial burden to people living with dementia. It's been estimated that the average annual out-of-pocket costs for people living with dementia is approximately \$1,000 per year.

But those numbers, as compelling as they are, don't necessarily tell the whole story. Behind the numbers there are the families, people and caregivers all experiencing the disease to some extent, but it's certainly possible for people living with dementia and their care partners to remain healthy and live well in the community if the right care and supports are available to meet their medical and social needs.

The dementia strategy that the government brought forward through the last budget is ensuring that people living with dementia and their care partners are, first, treated with respect, able to access information that allows them to make the best informed choices regarding their health care and well-being, and are living well with dementia, helped by the appropriate services and supports when and where they need them.

The strategy is built upon a person-centric model that is respectful of the preferences and the rights of the individuals with dementia. The strategy will raise awareness to reduce stigma associated with dementia and

educate people living with dementia and care partners and providers on prevention, treatment options and innovations in the area.

There is also a focus on accessibility and equity of care across the system. It is to ensure that it is both responsive to current needs and emerging needs that we learn about. We are engaging the full spectrum of services in the sectors to make it easier to develop comprehensive and coordinated care for people with dementia.

We are also working to ensure that there is an appropriate system-wide capacity across the full continuum of care. We are achieving this goal through evidence-based long-term planning, policy and investment decisions which I will articulate for the committee. We are also ensuring that our system is accountable and sustainable in the long run. We will do this through an ongoing evaluation of the quality of our services and our achievements.

Through our comprehensive consultation process on the dementia strategy, we heard from over 5,500 Ontarians, including those living with dementia, care partners, primary care practitioners, specialists, academics, researchers and community organizations such as the Alzheimer Society of Ontario. We were assessing their opinion for the purposes of understanding what the local best practices are, what the challenges are, and the opportunities in dementia care.

We started our consultation process in the fall of 2015 when former parliamentary assistant Indira Naidoo-Harris hosted eight round tables across the province in Mississauga, Ottawa, Milton, Brantford, London, Toronto, Sudbury and Thunder Bay. Having been personally involved in a couple of these consultations, it was quite humbling to hear people share their personal stories, but it was also very encouraging to understand how people are thriving in their community while living with the disease. What was heard loud and clear by the government was that, despite areas of success, there is certainly more that needed to be done.

In addition to the round tables, we set up an expert advisory group and five sub-working groups to provide tactical advice and expertise on what a comprehensive strategy should look like. The advisory groups and working groups that I mentioned were composed of experts from across disciplines and included people living with dementia and care partners. The five working groups were structured to follow a person's journey through the dementia disease states, starting with early to advanced stages of dementia, along with some groups

that gave us some advice related to education, prevention, research and innovation.

In order to ensure that the strategy was not being developed in isolation, we also established health-director working groups within the Ministry of Health, as well as inter-ministry working groups across government. The feedback, input and advice received from the round tables and various working groups was used to inform a discussion paper that was released for broad public engagement in early 2017. The engagement approach helped ensure that wide-ranging perspectives were heard, and it aligns with the open-government goals to increase public engagement in decision-making by reaching out to Ontarians, enabling them to shape policies and programs and services that affect their daily lives. It was this extensive province-wide consultation that helped inform our evidence-based five-pillar strategy.

Evidence tells us that dementia is the leading cause of dependency and disability among older adults. People living with dementia typically have two or more chronic health conditions. When compared to seniors without the disease, people living with dementia are twice as likely to be hospitalized or to visit emergency departments for avoidable conditions, and are likely to remain in hospital longer than necessary while waiting for more suitable care settings such as residential care or rehabilitation care. They often have more prescriptions and need to see a doctor more frequently.

For family and friends caring for someone with dementia, that can also have a significant effect on finances and on physical and mental health. As the disease progresses, the demands on the health care partners increase. Evidence shows that people caring for somebody with dementia provide 75% more care hours than other partners, and one in five care partners reports feeling distress, anger, depression or an inability to continue with that care. Care partners may also have their own health problems, with one quarter living with two or more chronic health conditions that are often aggravated by the demands of caregiving responsibilities within their home.

While these challenges may seem overwhelming, the government has implemented a comprehensive strategy to address—

The Chair (Ms. Cheri DiNovo): I'm afraid that's it. We stand adjourned until tomorrow at 3:45 p.m. Thank you, everyone.

The committee adjourned at 1800.



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